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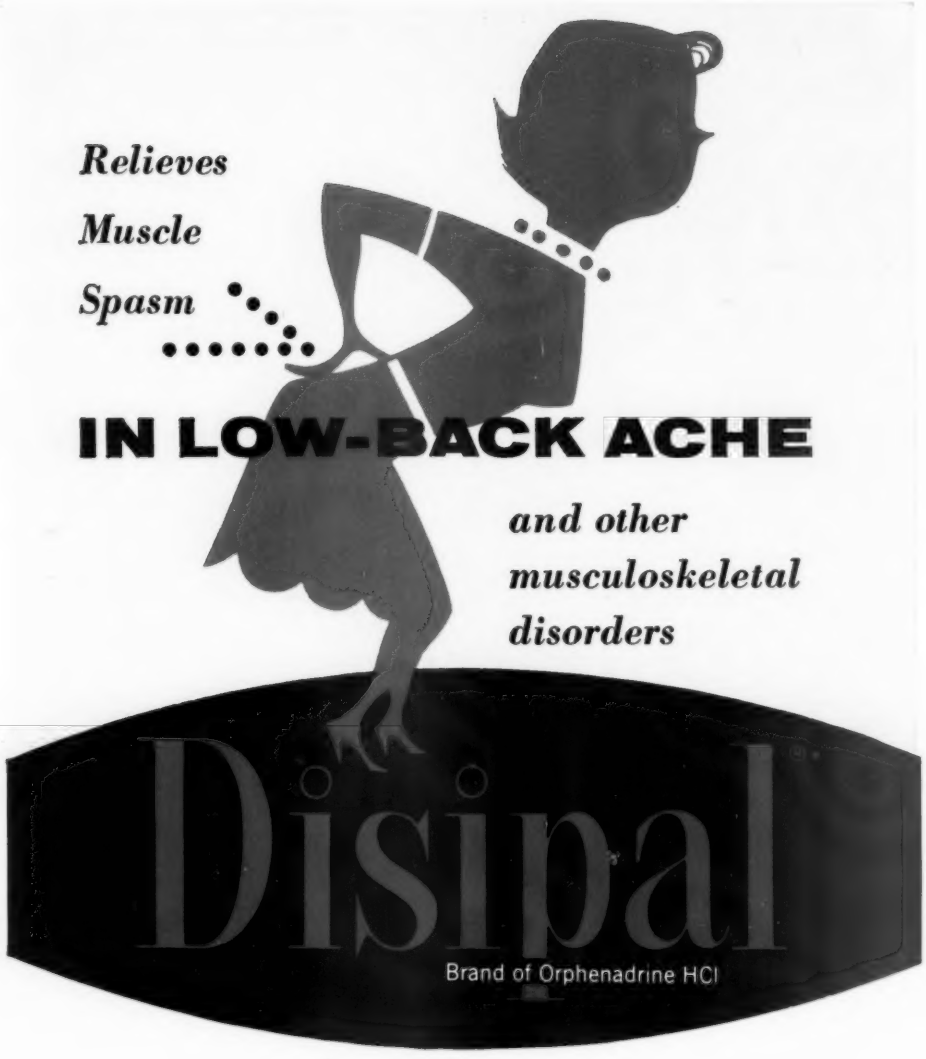

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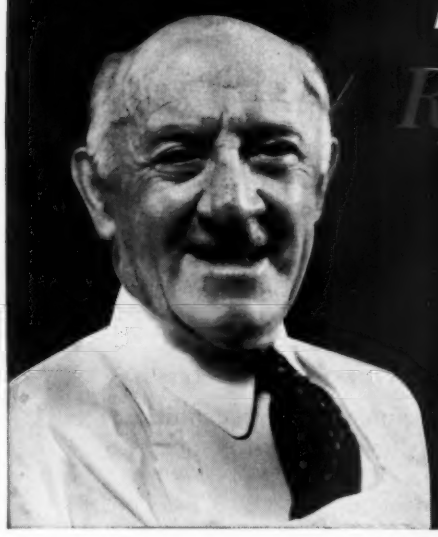

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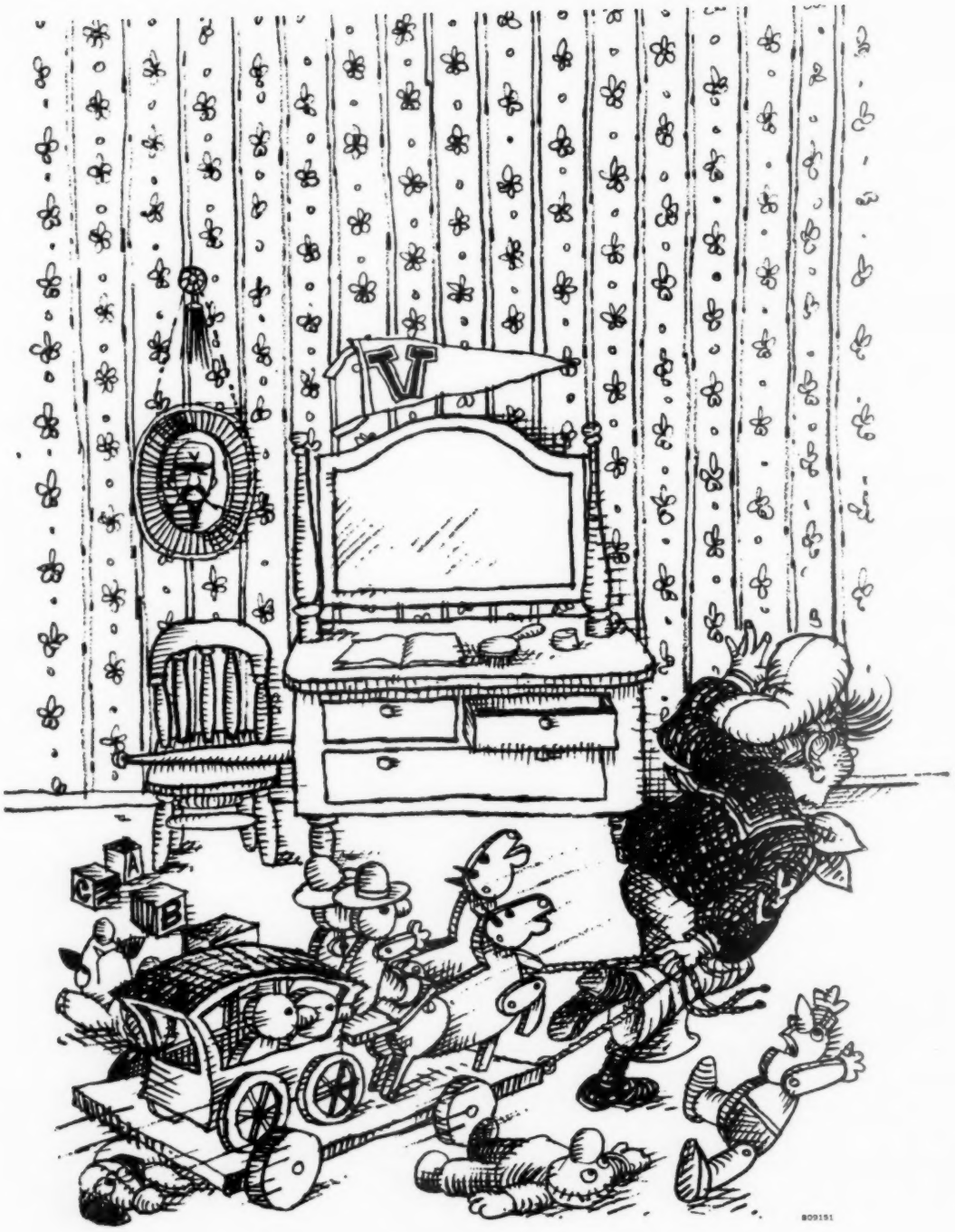

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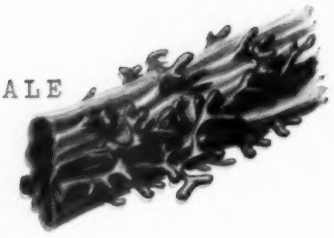
THE FEMALE  URETHRA

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1. Wharton, L. R. in Campbell, M.: Urology, Philadelphia and London, W. B. Saunders Company, 1954, vol. 2, p. 1390 et seq.

2. Barrett, M. E.: J. M. Ass. Alabama **26**:144, 1956. 3. Youngblood, V. H.: J. Urol., Balt., **70**:926, 1953.

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4. Youngblood, V. H.; Tomlin, E. M.; Williams, J. O. and Kimmelstiel, P.: Tr. Southeast. Sect. Am. Urol. Ass. (to be published).

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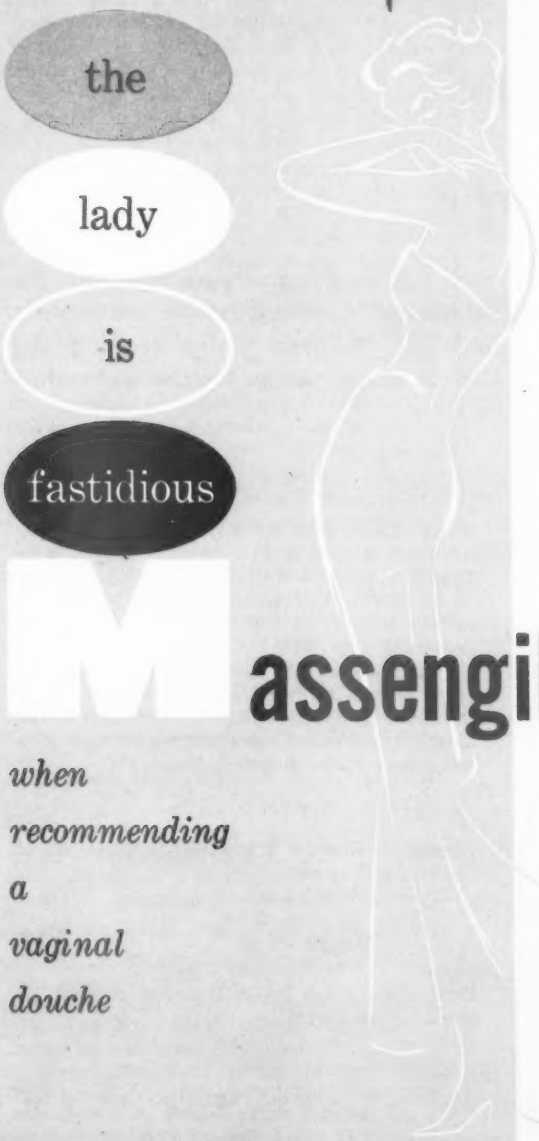

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1. Lang, W.R., Rakoff, A.E., Am. Geriatrics Soc. *1*:520 (1953).
2. Arnot, P.H., The Problem of Douching, Western Journal of Surg., Obs., and Gyn., Vol. 62, No. 2:85 (1954).

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At the same conference M. Harris Samitz listed as without value the administration of vitamins, gamma globulin, pancreatic enzymes, or special diets. He pointed out that there is evidence that many victims of psoriasis improve during the summer months and in warm, sunny places.

Mercury, salicylic acid, resorcinol, allantoin, sulfur, and detergents all have some action on the horny layer of the skin, Dr. Samitz said, adding that most of them, plus tar and podophyllum, act on the living epidermal cells. Steroids, he said, act on the inflammatory part of the disease, their primary function being to prevent oozing from the capillaries. Triamcinolone, a steroid hormone, is an effective new remedy, he reported. He suggested that it be employed in cases complicated (as psoriasis sometimes is) by arthritis, or in cases severe enough to justify steroid therapy.

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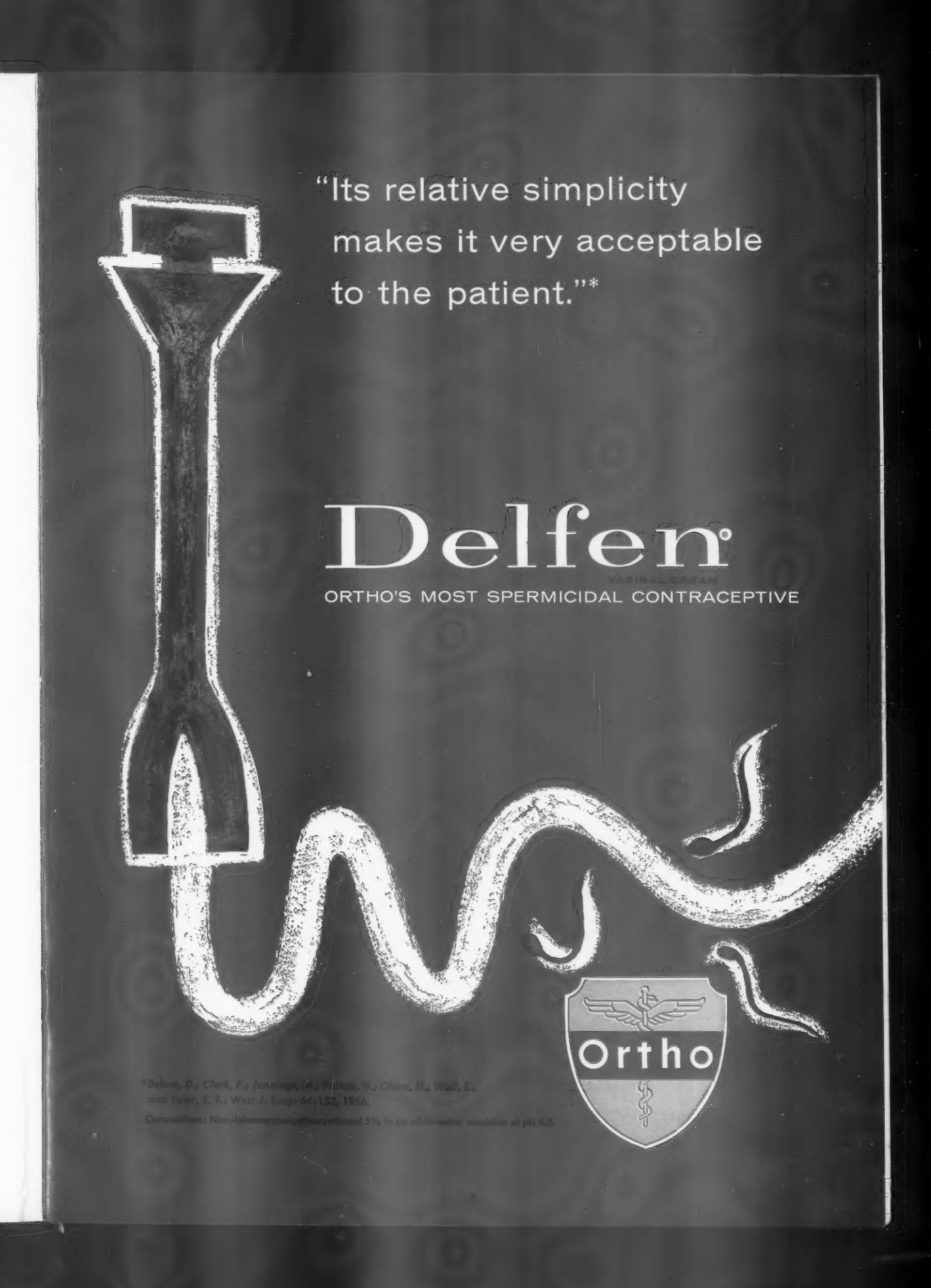
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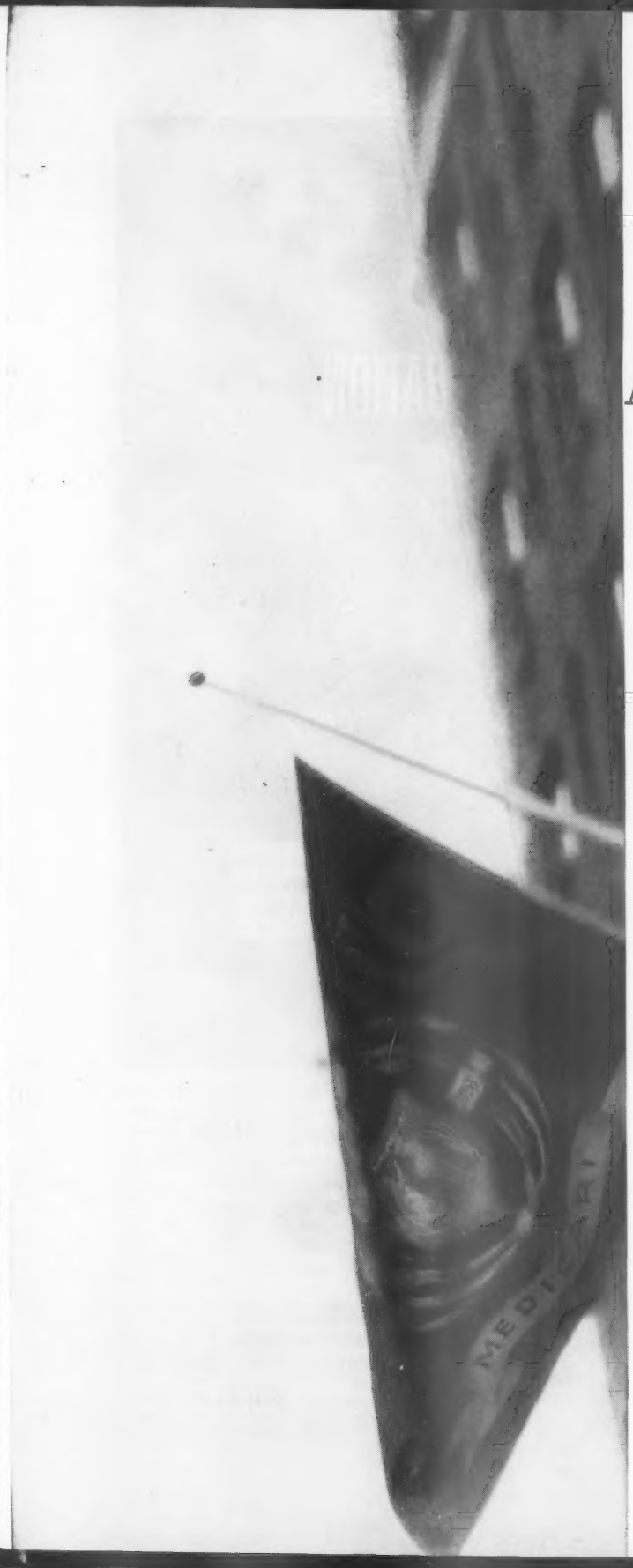

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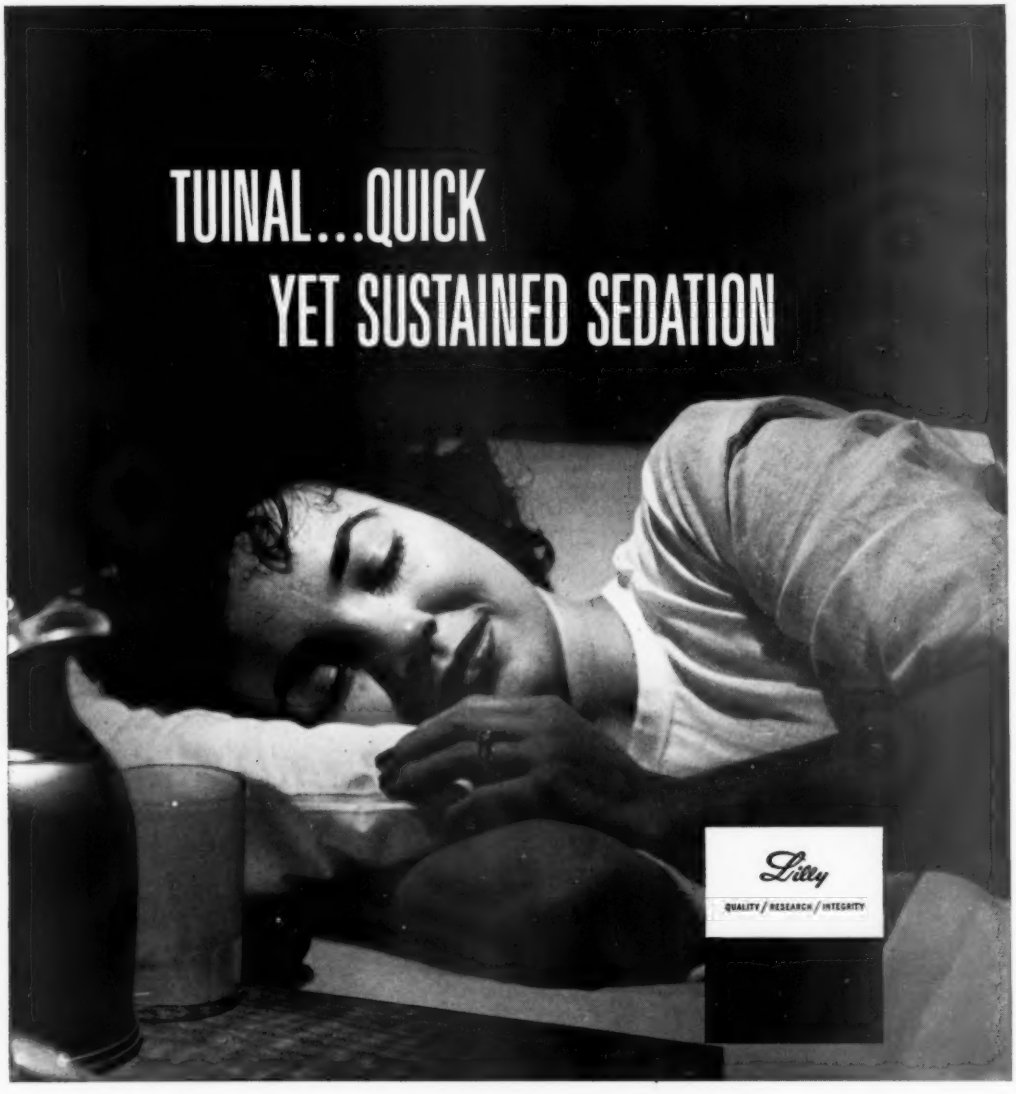

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Four Year Evaluation of an Antihypertensive Agent

Ella Roberts, M.D., F.A.C.P.

THE EFFECTIVENESS OF ANY THERAPY is measured in terms of its immediate benefits and by its ability to control disease over prolonged periods of time. This is particularly true with regard to drug therapy. For example, in conditions such as essential hypertension where drug therapy is often required for years, the effectiveness of an antihypertensive agent may become nullified by a tolerance that the patient develops to its therapeutic effect. Increasing the dosage, while effective in some patients, is often of little value because of the concomitant appearance of undesirable side effects. A recent report, however, suggests that preparations containing small amounts of several antihypertensive agents, each of which acts on a different site of the vascular complex and thereby produces a combined therapeutic effect equivalent to larger doses of a single drug, may be superior in this respect.[1] One such combination of drugs, containing rauwolfia, protoveratrine, and phenoxybenzamine (Mio-Pressin) in fixed amounts, has been reported on by several investigators.[2-5] Since these reports are encouraging in respect to the effectiveness of the preparation in mild and moderate hypertension when used for comparatively short periods of time, an evaluation was undertaken to determine its effect on hypertension for periods up to four years.

Dr. Roberts is Medical Director of Children's Heart Hospital, Philadelphia.

METHOD AND MATERIAL

Sixty-five patients (51 women, 14 men) were selected for evaluation on the basis of significantly elevated blood pressures and other symptoms associated with hypertension. Thirty patients were 60 years of age or older. Forty-seven patients had, in addition to elevated blood pressures, one or more of the following hypertensive symptoms: headaches (18 patients), chest pains (12 patients), dyspnea (7 patients), insomnia (7 patients), persistent fatigue (6 patients), and pulse or heart consciousness (5 patients). Mild neurotic symptoms, such as periodic moods of nervousness or depression, were present in 34 patients. Menopausal symptoms, manifested by menstrual disturbances, crying spells, and idiopathic gastrointestinal disturbances, were present in 17 patients.

Hypertensive histories of 1 to 15 years' duration were available for 59 patients. Accurate hypertensive histories could not be obtained for the remaining 7 patients, but all were known to have had symptoms of this disease for a minimum of six months. Previous therapy for these patients had included sedatives and/or various rauwolfia preparations, but the long-term results had been generally unsatisfactory, either because of inadequate control of the disease or the appearance of side effects.

Before being placed on therapy, all patients were examined by fluoroscopy or roentgenography to determine whether cardiomegaly had occurred. This was confirmed in 5 patients. Urinalyses, electrocardiograms, and blood urea nitrogen and blood sugar tests were also done, to eliminate patients whose hypertension was due to other pathological conditions.

Blood pressures over 159/90 mm. Hg were considered hypertensive, although this level is somewhat higher for systolic blood pressure than is generally used.[6,7] All the patients had blood pressures in excess of these values on repeated measurements during the period of observation preceding therapy. As can be seen from table I, initial blood pressures measured as high as 250 mm. Hg systolic and 130 mm. Hg diastolic.

After the initial period of observation during which diagnostic procedures were conducted, the patients were given the preparation, the components of which were present in the following ratio: rauwolfia, 12.5 mg.; protoveratrine, 0.1 mg.; and phenoxybenzamine, 2.5 mg. Initial therapy consisted of one capsule three times daily for all patients. If no subjective or objective changes occurred within one month, dosage was increased to one capsule four times daily. Those patients who did not respond to the increased dosage after one month were given capsules containing twice the amounts of each drug three times daily.

Patients were seen at two week intervals during the first month and monthly thereafter for periods ranging from one to four years.

TABLE 1

Effect of a Rauwolfia-Protoveratrine-Phenoxybenzamine Combination on Blood Pressure in Patients with Mild or Moderately Severe Hypertension

Degree of Hypertension	No. of Patients	BP Reduced to Normal	BP Reduced Significantly	BP Unchanged
Mild-moderate (160-220/91-110 mm. Hg.)	50	34	8	8
Moderate-severe (221-250/111-130 mm. Hg)	8	—	6	2
Totals	58	34 (59%)	14 (24%)	10 (17%)

RESULTS

The effectiveness of the preparation was measured by its ability to reduce blood pressure to normotensive levels, by the changes it produced in accompanying hypertensive symptoms, and by the incidence and severity of side effects that it produced.

Blood pressure reductions were categorized as follows: excellent, systolic and diastolic blood pressures reduced to normotensive levels; satisfactory, excess systolic blood pressure reduced at least 50 per cent and/or excess diastolic blood pressure reduced at least 75 per cent; and poor, all other effects on blood pressure.

Seven patients withdrew from the evaluation in less than one month because of nasal congestion (5 in the first week, 2 during the fourth week). Of the remaining 58 patients, 34 (59 per cent) achieved excellent blood pressure reductions, and 14 (24 per cent) achieved satisfactory blood pressure reductions. Significant reductions of blood pressure for these patients, regardless of the severity of hypertension, usually occurred during the first or second month of therapy. In 10 (17 per cent) patients, blood pressure was unaffected, but the patients were kept on the therapy because their symptomatic improvement was greater than that observed with other medicaments.

As can be seen from table II, the patients experienced considerable symptomatic improvement while receiving the preparation. Complete relief of headaches was reported by 61 per cent of the patients who had experienced marked headaches before the start of therapy. Only 2 per cent of the patients with associated hypertensive symptoms reported no improvement.

Eight patients, apart from the 7 who discontinued therapy, complained of mild, transient nasal congestion within the first two weeks of therapy. In 5 patients nasal congestion disappeared within six weeks, and in 3

TABLE 2

*Effect of a Rauwolfia-Protoveratrine-Phenoxybenzamine Combination on Clinical Symptoms Accompanying Hypertension.**

Symptom	No. of Patients	Complete Improvement	Partial Improvement	No Change
Recurrent headaches	18	11	6	1
Chest pain	12	2	9	1
Nervousness; tension	11	4	7	–
Dyspnea	7	–	5	2
Insomnia	7	1	6	–
Fatigue	6	–	6	–
Heart consciousness	5	1	4	–

* Multiple symptoms were present in some patients, while other patients were asymptomatic.

more patients the condition disappeared in eight weeks. Two of the latter patients, on their own initiative, used nasal drops containing vasoconstrictors and reported obtaining relief of nasal congestion with them. There were no other side effects.

Although the therapy was begun in all patients with one capsule three times daily, the dosage had to be increased to one capsule four times daily for 7 patients and to one capsule containing twice the amount of each drug three times daily for 10 patients. In 2 patients dosage was reduced to one capsule twice daily. Generally, however, one capsule three times daily was the effective amount for most patients. In 8 patients, the medicament was withdrawn at timed intervals, usually one capsule per month, after blood pressures became stabilized at normotensive levels for 12 consecutive months. In 7 of these patients, blood pressures did not become elevated after withdrawal of the medicament, even after 10 months. In the remaining patient, the blood pressure rose after withdrawal of the medicament to pretherapy levels (190/90 mm. Hg) over a period of 16 weeks. Restoring use of the medicament to the regimen reduced this patient's blood pressure to a normotensive level once more.

Considering all factors—reduction of blood pressure, relief of accompanying symptoms, and incidence of side effects—30 patients (52 per cent) had an excellent response to the medicament; 18 (31 per cent) had a good response; and 10 (17 per cent), while achieving some relief of accompanying hypertensive symptoms, did not experience changes in blood pressure. Seven patients withdrew from the evaluation too soon to permit a meaningful interpretation of their results.

DISCUSSION

The results obtained during this evaluation indicate that the rauwolfia-protoveratrine-phenoxybenzamine preparation is suitable for long-term therapy in essential hypertension, as well as for treating hypertension during the acute phase of the disease. No symptoms of tolerance developed, and side effects remained infrequent, mild, and transitory, even though the medicament was taken in some cases for as long as four years.

Most interesting are the 7 patients who, after withdrawal of the medicament, have remained normotensive. Several of these patients, of course, might have achieved and maintained normotensive blood pressures without therapy. On the other hand, 2 patients who discontinued therapy abruptly without direction from the physician suffered an immediate return of hypertension, while those who discontinued therapy gradually either remained normotensive or experienced a slow upswing of blood pressure that was easily controlled by reinstituting therapy. The possibility that prolonged antihypertensive therapy might in some patients possibly reverse the course of the disease has already been raised by several investigators.[8–10]

The drug combination appears to effect changes in blood pressure at fairly predictable intervals. From the start of therapy to the onset of significant blood pressure reductions, a period averaging one to two months intervenes; in another two months the combination appears to produce its maximal effect on blood pressures; thereafter, the combination is able to maintain blood pressures at the level achieved at approximately four months.

The fact that 7 patients discontinued therapy within the first month highlights the special problems encountered with patients in whom hypertension is associated with significant, prolonged emotional disturbances, as was the case with 5 of these patients. Previous therapy for these patients had also been interrupted by an inability to follow the prescribed regimen. For such patients, it is very likely that drug therapy would be more effective if used adjunctively to intensive psychotherapy.

SUMMARY

Sixty-five hypertensive patients (51 women, 14 men) were treated with a preparation containing a fixed ratio of rauwolfia, protoveratrine, and phenoxybenzamine. Seven patients withdrew from the evaluation during the first month, so that their reaction to the therapy could not be ascertained. The remaining 58 patients were treated with this preparation for periods up to four years. Blood pressures were reduced to normotensive levels in 59 per cent of these patients and to satisfactory levels in 24 per cent. After maintaining normotensive blood pressures with the drug combination for 12 months, 8 patients were taken off therapy with the medicament. Seven patients have remained normotensive to the present time; the remaining patient had a blood pressure elevation to pretherapy levels within four months. The blood pressure of this patient was reduced to a normotensive level by restoration of therapy.

Fifteen patients complained of nasal congestion as a side effect. Seven of these patients dropped out of the evaluation during the first month. In the remaining patients the condition cleared up within eight weeks. There were no other side effects.

Thirty patients (52 per cent) had an excellent over-all response to the medicament, and another 18 (31 per cent) had a good response. Ten patients (17 per cent) achieved relief of accompanying hypertensive symptoms, but did not achieve lowered blood pressures.

The rauwolfia-protoveratrine-phenoxybenzamine preparation is effective in maintaining reduced blood pressures for prolonged periods of time and therefore can be used when long-term antihypertensive therapy is required.

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The Problem of Postmaturity*

Eleanor Scott, M.D.

THERE ARE MANY WIDELY divergent opinions on the worrisome situation of postmaturity by those working with it, studying it, and writing about it. Opinions even vary completely as to whether postmaturity is a problem. Eastman,[1,2] Professor of Obstetrics at Johns Hopkins, makes the following statement in an editorial comment:

> There are a number of conditions in which induction of labor is thought to be indicated, but which are actually contraindications. One of these is so-called "postmaturity" of the fetus, that is, the status in which the patient goes a week to a month beyond the expected date of confinement. The infants in such cases are rarely larger than the normal range, and actually the "problem of postmaturity" is nonexistent. And even in cases in which the infants prove to be excessive in size, labor of spontaneous onset is helpful because, in general, it is less likely to be associated with inertia in this type of case than induced labor.

At the other extreme, Clifford,[3] a well-known pediatrician, feels that the problem of fetal mortality in postmaturity is second only to that in prematurity. He also states that in primigravidas over 27 years of age whose pregnancies last 300 days or longer, one out of every three babies will die, either in utero or in the postnatal period.

Opinion is also widely divergent as to the proper treatment. Those who do not consider postmaturity a problem believe that no treatment is necessary. Those who consider it a problem vary in their recommendations from inducing labor in every patient, either at term or at a specified number of days after term, to those who make liberal use of cesarean sections.

*Presented at the VI Congress of the Pan American Medical Women's Alliance, Miami, Fla., on April 15, 1958.

Dr. Scott of Baltimore is Obstetrician; Johns Hopkins Hospital; Assistant Attending Obstetrician, Sinai Hospital; Assistant Attending Obstetrician and Gynecologist, Franklin Square Hospital; and on the Courtesy Staff of the Hospital for Women of Maryland.

CRITERIA FOR POSTMATURITY

There have been criteria of weight, length, and gestational age suggested. Previously it was considered that a postmature fetus was also a giant fetus, and various weights have been suggested, such as 4,000 or 4,500 Gm. (9 or 10 lb.), as evidence of postmaturity. Recent work has shown that the rate of growth of the fetus proceeds quite regularly to about the two hundred sixtieth day of pregnancy, then continues to increase (but not at the same rapid rate) for the next 20 days, after which there is practically no change in the growth of the fetus. If anything, there is a tendency to lose weight. In other words, a baby who is going to be a big baby, a giant baby, is one who has reached that size a week before term, and any further prolongation of pregnancy has very little effect on the total weight of the infant.

Another method of gauging a baby is by length. It has been found impossible to define a postmature baby on the basis of any given length below which he is not postmature and above which he is.

Gestational age seems the most practical yardstick to use. Clifford[3] reviewed the work of some 30 authors, surveying a total of over 20,000 deliveries in which gestational age was used as a criterion, and found that 25 per cent of all pregnancies went beyond 287 days, or one week past term; 12 per cent went beyond 294 days, or two weeks past term; and 5 per cent went beyond 301 days, or three weeks past term. Most authors use 294 days as a criterion of postmaturity; some use 301 days. In this regard it should be pointed out that these are days counted from the last menstrual period and not from ovulation and conception. Stewart[4] estimated the duration of pregnancy and postmaturity on the basis of oral basal temperature records collected over five years. The duration of pregnancy from ovulation to spontaneous delivery in 135 women ranged from 250 to 285 days. Even though

eight pregnancies continued for 300 days or longer (one continued for 349 days) from the last menstrual period, they did not exceed 285 days from ovulation. In 1 patient 98 days elapsed from the last menstrual period to ovulation. Thus we see that by using gestational age figures we may or may not be dealing with true postmaturity. There will be many cases included that are merely "postdatism." Nevertheless, we need some criterion for comparison of results, and gestational age is the most convenient yardstick.

MORTALITY IN POSTMATURITY

I have compiled a table from the literature showing comparative perinatal mortality for mature and postmature infants, which also gives the number of days each author considers as postmaturity (table I).

From table I it can be seen that at some clinics there seems to be a higher mortality rate in postmature pregnancies, and, in others, little or no difference. The rates shown in table I favor those who say mortality is higher in postmature infants. Some authors have subdivided the mortality rate on the basis of whether the patient was a primigravida or multigravida and on the basis of age. Clifford[3] says that the mortality is 33 per cent in primigravidas over 27 years of age. Nesbitt,[5] on the other hand, has found an increase in fetal mortality in nonwhite primigravidas (though not nearly to the extent that Clifford has). His white primigravidas, however, do not show much of an increase in mortality over the postmature group as a whole (see table II).

Nesbitt's [5] figures (table II) were derived from analysis of 7,415 mature deliveries (fetus weighing 2,500 Gm. [5½ lb.] or more) seen during a period of four years at the Johns Hopkins Hospital. They show, in contrast to Walker's [6,7] and Clifford's [3] statistics, that there need be no more concern about a white primigravida over age 25 than one under 25—the rates are close, and both rates are close to the over-all postmature rate. In dealing with nonwhite patients, however, the postmature fetal mortality rate is 10 times that of the mature fetal mortality rate in primiparas under 25 years and about 5 times that of the mature fetal mortality rate in primiparas over 25 years. It seems, therefore, that in the nonwhite primigravida postmaturity is a matter of real concern.

TABLE I

Comparative Mortality of Mature and Postmature Babies

Author	Stillbirth Rate: Mature, %	Stillbirth Rate: Postmature, %	No. of Days Postmature
Hamilton (1951)	—	8.20	291
Latto (1951)	—	5.20	294
McKiddie (1949)	1.30	2.80	287
Clayton (1941)	4.25	6.15	294
Bacher (1953)	1.54	8.72	294
Hill (1952)	2.02	1.74	296
Nesbitt (1956)	1.15	3.57	294
Tucker and Benarm (1957)	1.40	1.30	301
Klosternak (1957)	1.00	3.60	301
Lindell (1956)	1.10	4.60	294

TABLE II

Perinatal Mortality According to Age, Race, and Parity (Nesbitt)

Pt.	Mature, %	Postmature, %
All cases	1.15	3.57
White primiparas under 25	0.52	4.11
White primiparas over 25	0.67	3.70
White multiparas under 25	0.48	0.00
White multiparas over 25	1.19	3.40
Nonwhite primiparas under 25	0.50	5.88
Nonwhite primiparas over 25	2.25	11.90
Nonwhite multiparas under 25	1.10	1.67
Nonwhite multiparas over 25	1.94	3.59

COMPLICATIONS IN POSTMATURITY

Some authors feel that placental insufficiency is the real problem in postmaturity, leading to a lack of proper oxygenation of the fetus. If this placental aging leading to insufficiency does not occur, the baby will not suffer from its prolonged stay in the uterus. Are there any criteria by which we can judge when this condition is taking place? Clifford [3] lists the presumptive signs for diagnosis of placental insufficiency as follows: (1) a decrease in amniotic fluid resulting in oligohydramnios—he says you may actually see the uterus shrink in size during the period of observation; (2) loss of weight in the mother—the mother often will lose 2, 4, or 6 lb. a week after term instead of continuing to gain or remaining the same; (3) meconium in the amniotic fluid—the only way to determine

this is by amniotomy, however, and once you have done that you are committed to delivery, whether or not the meconium is found; and (4) in postmature infants with damaged placentas, the fetal heart already exhibiting a prolongation of conduction time and other changes characteristic of a heart suffering from anoxia—a group at Mt. Sinai Hospital in New York studying electrocardiograms of the fetus in utero made this finding.

Nesbitt [5] found that a contracted pelvis, fetal distress, uterine inertia, prolonged labor, breech presentation, and post-partum hemorrhage are all significantly more frequent among postmature cases than among mature pregnancies. The greatest proportion of fetal deaths occurred during labor. These complications of labor are particularly hard on the fetus, which is already somewhat anoxic. This finding is in keeping with the significant increase in complications of labor noted in postmature pregnancies. He states that fetal death in utero of unknown causes does not represent the principal hazard of postmaturity.

The babies who are born to mothers with the placental insufficiency—postmaturity syndrome show characteristic findings. These are: maceration of the skin secondary to the disappearance of the protective layer of the vernix caseosa and staining of the baby with meconium, which is evidence of placental oxygen lack; if these changes have been present a week to 10 days before delivery, the vernix and the cord stains change to bright yellow. Many of these babies do poorly after birth.

DISCUSSION

When a patient comes to us two weeks past her due date how shall she be treated? She should be carefully studied to see whether she has any of the signs of placental dysfunction mentioned earlier. She should be carefully studied in regard to the presence of the other complications so frequently seen with postmaturity, such as toxemia, a contracted pelvis, and fetal malfunction, and these conditions handled as indicated. Cesarean section should probably be resorted to in cases of uterine inertia rather than oxytocin stimulation, which might cut off more oxygen from an already anoxic fetus. A short period of "watchful waiting" should be allowed before intervening in cases of postmature uterine inertia or of contracted pelvis, particularly in older primigravidas, as these anoxic babies do not stand rugged labors as well as mature ones do.

Routine induction of labor to prevent postmaturity would possibly bring as many complications as it would prevent, since routine induction would necessarily include a number of patients with long, closed cervices, floating fetal heads, and so forth. Also, whatever unknown facts, hormonal or otherwise, there are that cause the uterus to be late in starting labor seem to operate to cause uterine inertia more frequently when induction is carried out than when the onset of labor is spontaneous. Fortunately only a small group of the patients who are past their due date will have evidence of the placental insufficiency syndrome, but those who do challenge the obstetrician to use his greatest skill and judgment.

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Geriatric Conditions of the Eye

K. Elizabeth Pierce Olmsted, M.D., F.A.C.S.

IN MAN THE TISSUE differentiation of the eye is essentially completed at birth. Postnatal maturation of the eye consequently occurs earlier than in the rest of the body. Then, there is a somewhat stationary period between adolescence and middle age. The growth changes merge so gradually into the aging processes that no demarcation can be made, although the presence of local or systemic disease may hasten the degeneration.

LIDS AND CONJUNCTIVA

On external examination the eye may be sunken or enophthalmic, with partial ptosis of the lids and wrinkling and pouching of the skin. The lid margins often relax to produce an ectropion or become spastic to cause an entropion. In the conjunctiva small hyaline masses called phlyctenules, due to degeneration of the collagenous fibers and atrophy of the epithelium, are seen near the limbus.

CORNEA

To understand the changes possible in the cornea its anatomy should be briefly reviewed. The cornea is the transparent structure through which light rays enter the eye. It is composed of five layers: the epithelium, an anterior membrane of Bowman, a fibrous stromal layer, a posterior membrane of Descemet, and the endothelium.

Arcus Senilis. The most frequent change is the arcus senilis, the ring-shaped opacity located in the periphery, just inside of the limbus, caused by the deposition of lipids in the middle layers of the structure. It has no detrimental effect on the visual function of the eye.

Fuchs' Dystrophy. A less frequent but more serious disorder is the endothelial dystrophy of Fuchs'. This results from the deposition of lipid in the deeper layers of the cornea, causing a diffuse thickening of Descemet's membrane and degeneration of the endothelium. The process originates in the periphery and progresses slowly to involve the central zone. This disturbance causes an increased permeability of the endothelium, which then allows absorption of aqueous humor. Edema of the cornea ensues, with subsequent destruction of the epithelium from scarring and vascularization. Both the endothelial and epithelial dystrophy can be seen by biomicroscopic examination. The visual loss is proportional to the corneal involvement, but any amount of central corneal disease will reduce the acuity to 20/50, 20/70, or 20/200. The secondary epithelial change is rare but could easily reduce acuity to finger counting.

Trichiasis. The cornea may also become diseased due to irregular growth of the lid lashes so that they denude the corneal epithelium through contact and cause scarring and vascularization. Trichiasis may reduce the acuity to 20/200. Electrolysis of the lashes or repair of the entropion can avoid this disaster.

AQUEOUS HUMOR

Glaucoma. In the normal eye aqueous humor is secreted by the ciliary body into the posterior chamber, the area between the lens and iris. It then circulates through the pupil into the anterior chamber, which is the space between the iris and cornea. From here it is filtered back into the blood stream through the meshwork at the angle behind the limbus at the junction of the iris and cornea. A stable healthful pressure between 10 and 20 mm. Hg measured by the Schiøtz tonometer is maintained through the proper flow of the aqueous humor. If the circulation is slowed or the path blocked in any way, an increase of intraocular pressure builds up, resulting in the abnormal state named glaucoma.

If the circulation is blocked at the pupillary passage, building up pressure behind the iris

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and bulging it forward to block secondarily the anterior chamber angle, an attack of acute glaucoma results, producing the clinical picture of a patient with severe prostration, nausea, and vomiting, who lies curled up and holding his eye due to the excruciating pain. The eye is congested, the cornea is hazy, the pupil is dilated, and the eyeball is stony hard. The tension may measure 90 mm. Hg or more. This is a surgical emergency. If an opening or iridotomy is made in the iris to re-establish the circulation between the posterior and anterior chambers before extensive adhesions develop, this condition is alleviated. If proper treatment is delayed, the acute phase passes into a chronic state and must be handled accordingly.

A chronic condition arises as the trabeculae of the drainage channels become hyalinized and sclerosis of the drainage vessels decreases the facility of outflow of aqueous humor, causing the slow elevation of intraocular tension characteristic of simple glaucoma. Here the clinical picture is the antithesis of the former because of its remarkable absence of symptoms. One can sometimes obtain a history of discomfort in the eyes during reading, excessive tearing, or periodic blurring of vision or pain in the eyes during the night. The visual acuity remains good until total blindness takes over. The eyes usually appear normal unless there is a marked elevation of pressure, in which case a faint circumcorneal infection may be present. A tonometric reading may reach 25, 35, or 40 mm. Hg, but it may be necessary to institute provocative tests to establish the diagnosis. Treatment consists of increasing the outflow of aqueous humor by the continued use of medicaments or, if this fails, by surgical intervention. The preservation of vision depends on an early diagnosis and continuity of care. This disease is the greatest cause of blindness in the United States today, and statistics show that 2 per cent over 40 years of age have undiagnosed glaucoma.

LENS

Presbyopia and "Second Sight." The most common senile changes in the eye are found in the crystalline lens. The lens is a transparent ovoid structure suspended by a zonule separating the aqueous chamber and the vitreous chamber. Its function is to focus the rays of light entering through the cornea onto the retina. A change of focus is obtained by altering the tension on the zonule, which allows the lens to expand for accommodation to near objects and to flatten for distance focus. Sclerosis of the lens fibers reduces this flexibility and a gradual loss of accommodation results, called presbyopia. This becomes noticeable in patients in the middle forties and necessitates the use of reading glasses or bifocals. As further sclerosis occurs the lens becomes less transparent, causing a change in the refraction to the myopic side accounting for the celebrated "second sight" of old age.

Nuclear and Cortical Cataracts. The lens structure is unique in that the growth of new fibers occurs from the epithelial layer at the outer circumference of its body, displacing all former fibers inwardly. This results in a central core of old fibers, the nucleus, surrounded by a soft colorless layer of lens substance called the cortex, all confined within the lens capsule. With advancing age, sclerosis of the nucleus is a normal manifestation. If, however, the nucleus becomes so dense as to obstruct useful vision, the condition is classified as a nuclear cataract. Degeneration may also occur in the cortex where liquefaction of the cortical fibers causes opaque areas and subsequent cortical cataract. Of the two types of senile cataract, the cortical type is the more rapidly progressive, sometimes reducing vision below 20/200 within two years, while the nuclear type may advance slowly over a 15 year period. Of course, both processes may be evolving simultaneously. There is no therapy to be used other than the maintenance of a good general physical condition. The operative treatment is the extraction of the lens at the proper time. This may be done by the extraction of the lens within its capsule (the intracapsular method) or by the excision of the anterior capsule and the expression of the lens substance (the extracapsular technique). A secondary cataract can develop only after the extracapsular extraction, when remaining lens material may proliferate into an opaque membrane. There are definite indications for each approach.

RETINA AND CHOROID

Considerable importance must be given to lesions of the retina and choroid as causes of senile visual loss. The choroid is a dense vascular layer bounded externally by the firm sclera and internally by Bruch's membrane, to which the retina is intimately attached. The retina

is composed of the visual neurons and their supporting neuroglial structure. The outer nuclear layer receives its blood supply from the choroid while the inner layers are supplied from the central retinal artery.

Detachment. The posterior chamber of the eye is filled by the vitreous body. The vitreous humor is firmly attached at the ora serrata retinae and at the ciliary epithelium, but with advancing age it also adheres to the retina more posteriorly. In older persons the vitreous humor commonly liquefies. This may occur centrally, leaving the solid vitreous humor to protect the retina peripherally. It may, however, liquefy posteriorly, resulting in forward contracture of the solid portion, thus producing the so-called posterior vitreous detachment. Along with this retraction there is pull on the abnormal retinal adhesions, which effects tears in the retina and subsequent detachment.

Arterial or Venous Occlusions. A disturbance in lipid metabolism may subject the ophthalmic artery to atherosclerosis along with the other arteries of the body. Atheromatous plaques are laid down in the walls of the artery and in its arteriolar branches, which grow to occlude the lumen or ulcerate to cause thrombosis. Fibrosis, occurring in the involved areas of the vascular wall, may be observed ophthalmoscopically as an irregular white sheath surrounding the blood column. Similar masses may also form in the walls of the retinal veins to block their lumen. The damage sustained by the retina results from the arterial or venous occlusions. In arterial occlusion, ischemia causes disintegration of the adjacent retina. In venous occlusion, hemorrhage and edema are followed by necrosis, cystic degeneration, and neovascularization.

In the arterial system the most serious occlusion occurs in the central artery. The view of the fundus shows the arteries contracted to threads while the veins appear thin and dark. The retina becomes pale and the macula cherry red. There is sudden loss of vision, which is usually permanent, although some vision may be recovered if the obstruction is of short duration. Obliteration of a branch arteriole causes a localized area of edema at the terminal portion of a sclerotic patch in the vessel. A visual haze occurs at the onset, which persists as a scotoma.

Obstruction in the venous circulation is equally dramatic. After occlusion of the central vein, the veins in the fundus become engorged and dilated, winding tortuous paths in the damaged retina. The entire retina is filled with brush-stroke-appearing hemorrhages destroying all detail. The clinical result is a progressive loss of vision with eventual blindness. A secondary hemorrhagic glaucoma occurs in about 20 per cent of cases, necessitating the removal of the eye. Branch thromboses produce a sector involvement with less drastic results.

Cystic Degeneration. The aging process in the retina is evidenced by the gradual atrophy of the neuronal elements associated with an increase of the glial tissue, resulting in the formation of cystlike spaces. This cystic degeneration usually occurs in the periphery of the retina where rupture of the disintegrated areas establishes holes or tears in the retina. Occasionally these pathological changes occur in the macula, and a cystoid degeneration develops that impairs visual acuity. Complete loss of central vision may result if the process progresses to destruction of the fovea and to production of a macular hole.

Colloid Degeneration. Sometimes Bruch's membrane becomes involved in the deposition of hyaline material, which form colloid bodies under the retina, and a subsequent colloid degeneration of the retina results. The neurons are not primarily involved so that visual impairment is not severe, although the ophthalmoscopic picture looks frightening. The fundus is studded with discrete yellowish white nodules, which appear to fill the entire retina. These often are more numerous in the macular area, coalescing to obscure all normal features.

Central Senile Chorioretinal Degeneration. There are two distinct forms of central senile chorioretinal degeneration. The more common form originates in the choroid as a result of atherosclerosis and obliteration of the blood vessels, hyaline deposition, and pigmentary disturbances. Subsequent to the choroidal breakdown there is a reduction of nourishment of the retina, causing disintegration and atrophy of the macular region. This condition is always bilateral, although the condition may be more advanced in one eye than in the other. There is a progressive loss of vision associated with a disturbing fragmentation of detail, especially noticeable in reading. Patients complain of being able to see something at one moment and not the next, and seeing better on one day than on another. Ultimately, all central vision may be lost. The fundal

changes range from slight pigmentation of the macula to complete retinal atrophy, revealing the network of sclerosed choroidal vessels. The visual loss cannot be readily estimated from the ophthalmoscopic findings, as even minute changes may cause a disastrous reduction in visual acuity. The second type of degeneration is caused by a hemorrhagic or serous exudate from the choriocapillaris extruding through a break in Bruch's membrane to form a massive elevation of the retina in the macular region. Organization of the hemorrhage follows, with subsequent invasion by connective tissue and blood vessels from the choroid and glial proliferation of the disorganized retina. The final result is total destruction of the area and complete loss of central vision. The visual deterioration is rapid, but fortunately the condition is frequently unilateral so that the loss is less disturbing. The clinical picture is a large elevated dusky red and white mass, often filling the entire macular area between the superior and inferior temporal vessels.

There is little treatment for senile macular degeneration. Retardation is strived for through the maintainance of good general health, with proper nourishment and physical care. Recently some favorable results have been obtained with lipoid substances. Assurance may be given to the patient that only central acuity is involved so that, although there will be inability to read and do fine work, there will always be sight enough to eat and dress and to navigate in familiar quarters. Optical aids for the near blind may be of some value at the onset of the more insidious types of disease processes.

Cerebrovascular Disease

Hope for improving the outlook in cerebrovascular disease, which is outranked only by heart disease and cancer as a cause of death in the United States, rests principally upon a long-term research program, the development of new methods of treatment, and greater use of the best methods now available.

The cerebrovascular diseases—primarily cerebral arteriosclerosis, cerebral hemorrhage, embolism, and thrombosis—currently account for some 185,000 deaths a year in the United States, or about one eighth of all deaths. It is estimated, moreover, that at least 2,000,000 persons are handicapped or incapacitated by these conditions.

Dental Survey

A new study by the Public Health Service's National Health Survey showed that only 36 per cent of the people had visited a dentist during the preceding year and that, as of August, 1957, 42 per cent of the American people had not been to the dentist for three years or more. The survey also showed that more than 21 million persons, or 13 per cent of the population, have lost all their teeth.

Plastic Blood Pack Unit

Armed services have gone into production with a standardized plastic blood pack unit that is markedly superior to glass from the standpoint of bulk and weight. A twin improvement is the newly developed disposable blood refrigerant shipping container, which is lighter than cartons used previously and which makes returns of "empties" unnecessary. It is virtually certain that the plastic transfusion unit will take the place of glass equipment as far as the military is concerned.

The Internist Looks at Alcoholism*

Lila Bonner Miller, M.D.

THE "OLD LOOK" AT ALCOHOLISM was never very satisfactory to any of us for many reasons. The alcoholic was sick at inconvenient times—after office hours, late at night, or on holidays; he had no money for drugs or food; he was a dangerous person to whom to administer narcotics; he was dehydrated and often vomited everything taken orally; and hospitals would not take him. If too little was done or if too much was done, he might die. The physician felt inadequate. Let the police handle him—he was drunk anyway. If he died in jail, the private physician would not know about it. The fault would lie with the city, and the health officer would just be asked to sign the death certificate. As physicians, we marked the alcoholic off our list mainly because we felt inadequate.

In the last 10 or 15 years, a "new look" has come to alcoholism. It came not through the medical profession but from the alcoholic himself, through Alcoholics Anonymous. Since then, physicians, psychiatrists, society in general, the church, and the family have begun to accept the new look for the alcoholic. Now, instead of pronouncing judgment and calling the alcoholic a "drunk," he is recognized as a sick person. New drugs, such as tranquilizers, have been found helpful in combating this disease. The Council on Mental Health of the American Medical Association recently accepted a resolution that an alcoholic should be treated in the general hospital as is any other patient. Through Alcoholics Anonymous, many alcoholics are getting well and taking their place in society as useful citizens. State governments are appropriating money to treat the alcoholic, for it is good business to help secure health for the alcoholic so that he can support himself and his family. Finally, it has been realized that the alcoholic, as a sick person, needs the resources of the state, the physician, the psychiatrist, the church, the family, and society, in order to regain health. The Yale School of Alcohol Studies brought into focus the many aspects of the problem.

Specifically, what does the new look mean for the internist? The first step is to accept alcoholism as a sickness. Its third stage, which consists of the occurrence of lost week ends, black-outs, the daily morning drink, with an extra drink to do a job or because of incapacity to do a job, and an existence from drink to drink, leading often to convulsions or delirium tremens, ends either in insanity or death or in good health. In this regard, we have to get the hospital staff we work with to accept the management of a few alcoholic patients to see if they can tolerate treating the alcoholic in the general hospital. Then, we have to make the diagnosis of "alcoholism" and not hide it behind its results, such as cirrhosis of the liver. In one hopital where a 66 year old man died, the diagnosis was pulmonary edema, cirrhosis of the liver with fatty metamorphosis, ascites with blood clots, and hepatosplenomegaly. Only in the patient's history was mention made of the fact that he drank $300 worth of liquor a month.

When the physician also deals with his patient honestly and confronts him with the diagnosis of alcoholism, the first step has been accomplished. The second step is that the physician must realize that, if the patient is in the third stage of alcoholism, he is unable to stop drinking without help and that, without help, insanity or death will occur.

The following paragraphs from an unpublished report describe the treatment Dr. Vernelle Fox, Director of the Georgia Rehabilitation Center for Alcoholics, uses in her private practice when treating acute alcoholics.

*Presented at the VI Congress of the Pan American Medical Women's Alliance, Miami, Fla., on April 15, 1958.

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If the family calls and the patient is grossly intoxicated, whether disturbed or plain drunk, you would not like to have him in the hospital at that moment and yet you know that he is a candidate to sober up and to get started in rehabilitation. I have found it a simple procedure to go by his house and give him 50 to 75 mg. of promazine (Sparine), which will put him to sleep. In the meantime, I call the hospital and make arrangements to have him admitted the next morning. By the next morning, he is going to have the shakes and be sober enough to behave himself and make sense: he usually is perfectly glad to go to the hospital and get off his bender. Without these facilities and your help, he would probably continue to drink and go along on this bender until such time as he has intractable vomiting or is too broke to buy another drink. By the next morning, most patients are sick but not drunk enough to be a disturbance in a general medical ward. On his arrival at the hospital, give the patient 75 to 150 mg. of promazine intramuscularly and initiate a 100 mg. dosage every four hours orally, with an alternate 400 mg. dosage of meprobamate (Equanil) every four hours. This will usually manage the tremulousness, nausea, vomiting, and other distressing symptoms. If the patient has had much vomiting or shows evidence of clinical dehydration, he should be given 1,000 to 2,000 cc. of glucose and saline solution parenterally. I have found that this is seldom necessary. If he has a history of gastric distress, previous ulcers, or gastritis, I usually put him routinely on antacid therapy for the protection of the gastric mucosa. All patients should receive large daily doses of vitamins parenterally, usually in the form of a high vitamin B complex containing 100 mg. of thiamine, 100 mg. of nicotinamide, and 10 mg. of pyridoxine, along with 500 mg. of vitamin C and 100 μg of vitamin B_{12}. This may well sound like a shotgun mixture and actually it is, but everyone working in the field has been overwhelmed by the gross dietary indiscretion and inadequacy of these patients and by the great demands put upon their metabolic stores by a large consumption of alcohol. This therapy is usually sufficient, given over a three or four day period intramuscularly. In few patients have I found it necessary to give vitamins intravenously. With the use of an ataraxic, I have not found it necessary in many instances to give hypertonic glucose and insulin for detoxification. In a fairly high percentage of patients I find that calcium, given parenterally for one or two days, is indicated. The manifestations of calcium deficiency are muscle fasciculations or, in the milder forms, muscle cramps. A laxative is usually indicated in most of these patients on the second hospital day.

At the time you make the rounds on the second day, you usually find that your patient is eating and taking adequate fluids, that he has had some intermittent sleep the night before, and that, although he still feels fairly ill, he is beginning to show evidence of wanting to get back on his feet and return to work. At this time, you can usually begin to decrease the dosage of tranquilizers and have the patient up and around the ward a little bit. This is an excellent time to begin to work with him in the hope of being able to guide him to a long-range program of rehabilitation, such as an alcoholic clinic, AA, individual psychotherapy, or whatever else you may feel is best suited to his needs. Almost always, at this point, the patient will be full of remorse and guilt feelings and quite willing to accept help. He will be certain that he must never take another drink again. A fatherly, stern lecture of "You ought to be ashamed of yourself; now be a man and don't drink so much next time" is exactly what the patient would be most comfortable with and is exactly what will prevent you from being of any real benefit to him. This is the strategic moment to sit down and listen to him. Let him know that you know he is a total human being with many problems, that he is quite worthy of your consideration, and that he is in serious need of help.

The third step is for the internist to say to the patient: "I know you tried hard not to go on this last bender and maybe I can help you help yourself." This gives the patient courage to begin the long process of rehabilitation. Thus, through the physician, the patient gets a view of the possibility of his recovery from alcoholism. The attitude of the internist may be the turning point in the patient's recovery!

Again, the physician must be more concerned about the fact that disease and death from alcoholism are preventable. Probably every physician who sees symptoms resulting from alcoholism has already told his patient not to drink; however, telling a man not to drink is not enough. After an operation the surgeon does not merely tell the patient what to do; he sets processes going whereby someone helps the patient out of bed, and does this every day until he can walk by himself. If a patient needs roentgen-ray treatment, the physician also arranges that. In a case of tuberculosis the patient is not just told to stay in bed and take some medicine. Physicians have led the way in building up enough public concern so that there are sanatoriums where the patient with tuberculosis is sent to receive help in resting. To prevent some of the deaths that occur as a result of alcoholism, the internist should evidence a concern about these deaths, whether they are in our hospitals or in the city jail—a concern over the prevention of these deaths is very important. The task in alcoholism, just as in the case of tuberculosis, is too big for one person alone; but, the physician's knowledge, interest, and attitude can lead the family, the psychiatrist, the church, and the state in helping the 4 million alcoholics

in the United States find health instead of insanity or death.

REHABILITATION CLINIC

In connection with my working half time as an internist in the Georgia Rehabilitation Center for Alcoholics, you may be interested in some methods used there. This center is located in Atlanta. It consists of a 40-bed hospital, an outpatient clinic in the hospital, and an outpatient clinic in Savannah. Since October, 1953, 2,552 patients (2,169 men and 383 women) have registered for treatment (1,402 inpatients and 1,150 outpatients). Of these, 67 per cent have a good potential for recovery and have maintained contact with the program, and 33 per cent, at the time this study was made, have not improved; 675 have materially improved, re-established family, and broken their drink pattern to the extent of holding a job. If these 675 earn an average of $200 monthly, they have totaled an annual income of over 1.5 million dollars. The cost of the Clinic is $200,000 a year.

Certain principles guide us: 1. There are no locked doors or gates. 2. The patient is treated as a man who is responsible for his own behavior. 3. If drinking occurs on the premises, the patient who drinks is discharged. If he comes back sober the next day, he will be considered in the routine way for a period of several days as a candidate for admission. 4. Motivation is considered the first criterion for admission. Does this patient want help with his alcoholic problem? That his family wants him to stop drinking or that the judge sends him is not enough. There is a three to five day preadmission period, during which time it is seen whether he can maintain his sobriety with the aid of tranquilizers and whether he is psychotic and too mentally ill to be treated in our Center. He is evaluated for admission in one pyschiatric interview. 5. He is advised that his stay will be from six weeks to three months, or thereabouts, and that he will, working with his counselor, set his own ending date. This setting of the ending date is used as a tool to enable him to make a decision of vital importance to him and to accept its consequences. 6. If the patient goes out and gets drunk, then returns and asks for help, he is always received when sober at the outpatient clinic and in the outpatient group meetings. He will be considered and probably accepted for readmission once.

An effort is made to have the hospital be a therapeutic community in which there is a closeness between the staff and patients. The program consists of an intake period during which a thorough history is taken by a social worker and in which there is an interview with the director. A careful physical examination by an internist is done during this time and medication is given, consisting mainly of tranquilizers and vitamins (no barbiturates are used). Then there is an orientation period. If the patient has to stay in bed, he is too sick for this program and is not admitted. A week of kitchen work is part of the program.

The staff consists of a layman who is the executive director; an internist who is the medical director; two psychiatrists who interview the patients three times (before admission, two weeks later, and before they leave); an internist who gives all physical examinations; an internist who does only group work; a full-time chaplain who is trained in pastoral counseling, together with four part-time ministers trained in counseling; a psychologist who does group therapy; two social workers; seven nurses; an occupational therapist; a laboratory technician; and a maintenance staff.

Every patient has one hour a week of individual counseling and approximately 10 hours a week of group therapy. Since group therapy is a potent therapeutic tool at our Clinic and a major part of the program, the following data are presented:

The patients are divided into three groups, each consisting of about 12 to 13 patients; the outpatient groups include from 12 to 20. The inpatient groups are closed; the outpatient groups are open. There are seven groups of outpatients and two family groups a week.

The role of the group leader is as follows: 1. He conveys acceptance, warmth, and understanding. This is the patients' group, and what they say and feel is accepted. 2. He attempts to attend to the needs of others. 3. He seeks to understand the real meaning of what is being said. He listens, according to Reik, "with the third ear," and picks up much that is nonverbal communication. 4. He accepts the group in the stage it is in and works with the members. 5. He attempts to link together what is being said.

The group matures at first in somewhat the same stages as does an individual. Some respond to the power ethic instead of to the love ethic. The individual in the group feels more understood. He has obtained relief in

telling his story. Others listen to him. He feels more accepted by others, more secure, more able to express his feelings, and more able to understand himself. He feels that responsibility for evaluation lies within himself. He is frightened by this responsibility, yet this gives him hope that he had lost. The group, instead of being made up of individuals, becomes one —almost a family in a way. There may be one who takes the place of the father figure, one who gives the warmth of the mother, one who may be the hostile little child, and one who may be the silent, hostile adolescent. In the process of maturing, the individual has many "ups and downs," but the group appears to be a small world in which he is known for what he is, is accepted, is challenged, and is thwarted by others, and in which he learns that there are some limitations and that he must accept them. He feels the warmth and love of the group, and hope and self-understanding begin to emerge. The individual has a chance to take several steps forward toward the goal of maturity. As a result he is better able to handle his problem of alcoholism and the other problems that arise.

Public Health Programs for the Americas

In September, 1957, at the tenth meeting of the Directing Council of the Pan-American Sanitary Organization, a program and budget for 1958 was adopted, which included some 160 public health projects and a budget of 3 million dollars, an increase of $600,000 over the 1957 budget. The work of the Bureau in 1958 is also being financed by a regional allocation of World Health Organization funds amounting to $1,558,502. United Nations Technical Assistance Funds for this international health work in the Americas in 1958 is expected to reach $1,275,308. Since proposals for the WHO regional allocation of funds must be made over a year in advance, the Directing Council approved at this meeting a recommendation for a WHO allocation of $1,599,364 for the Americas in 1959. The Council also noted a tentative proposal of a program and budget for the Bureau for 1959 amounting to 4 million dollars.

An exhaustive analysis was made of all public health programs in which the Bureau will lend its assistance to governments and administration, on their request, in 1958. Covering practically every field of public health, the work may be broken down into four general areas in which particular emphasis is laid. 1. Eradication campaigns, with malaria heading the list in importance, and calling for intensification of programs to eradicate the urban carrier of yellow fever, the *Aedes aegypti* mosquito; the eradication of yaws (the number one health problem in Haiti seven years ago, now virtually eradicated from that Republic); and the eradication of smallpox. 2. Other communicable diseases, in the prevention or control of which new and more efficient methods are now available, including preventive or therapeutic measures against such diseases as tuberculosis, leprosy, poliomyelitis, and influenza. 3. Strengthening of national health services, with greatest emphasis on the development of plans and more efficient means for the evaluation of current programs. 4. New activities of the Bureau in the field of public health, such as chronic diseases, occupational health, food and drug services, and nuclear energy in its bearing on public health.

At the 34th meeting of the Executive Committee of the Pan-American Sanitary Organization, held on May 15, 1958, how to invest some millions of dollars wisely in the future health of the Americas was the main topic of discussion. This money, supplemented by a Special Malaria Eradication Fund, represents what PASO is proposing to spend as its share for international health work in the Western Hemisphere. The funds are proposed for use in continuing the far-reaching antimalaria campaign launched by PASO in 1954, and to provide for maternal and child health projects, poliomyelitis studies, smallpox vaccination drives, plague investigations, nutrition studies, and leprosy control—to name but a few of the 100-odd projects the Organization is considering for next year.

Robert Anderson Cooke and the First Allergy Clinic*

ROBERT ANDERSON COOKE is to allergy what Sigmund Freud is to psychoanalysis. Before Dr. Cooke there was no such thing as an allergist, and "allergy" was a word coined by Clemens von Pirquet, an Austrian, several years earlier to describe a type of horse serum reaction. Today there are some 1,500 allergists in the United States, and probably an equal number throughout the rest of the world, and allergy is a recognized distortion of physiological response playing the major or contributory role in hundreds of human ailments. Before the days when Dr. Cooke turned his attention to this phenomenon, many allergic manifestations were called "idiosyncrasy" and no treatment was available for them. Today, largely as a result of his work, most allergic conditions can be diagnosed with certainty and treated effectively.

Robert Anderson Cooke was born in Holmdel, N. J., on Aug. 17, 1880. At age 20, he graduated from Rutgers University with a B.A. degree and four years later earned his M.D. degree from the College of Physicians and Surgeons, Columbia University. He spent two years as an intern at Presbyterian Hospital, where his greatest difficulty lay in ambulance service. From the age of 8 he had experienced severe and recurrent asthma. This was especially bad when he was near animals of any sort. Even as a child he realized this, and, although he loved animals, he did his very best to stay away from them.

As an intern, he was called upon to ride an ambulance numerous times during the day, particularly in the summer in answer to calls for those stricken with heat prostration. There were some days when he was called out 20 and 30 times. And, at every call, he experienced severe asthma, so that, for the two years spent at this hospital, he was in an almost constant state of asthma. In those days, of course, the ambulances were horse-drawn. Sitting behind the horse with the wind whipping horse dander into his nose and throat, he was a perfect target.

Whether this unfortunate situation would have led the young Dr. Cooke into the work to which he was later to devote himself entirely is a question. For one thing, he knew his ambulance duties were to extend for only two years and, for another, although the attacks were bad, they were relieved when he was off ambulance duty. However, there was one incident that made so deep an impression upon him he could not rest until he understood it clearly. It was the search for this understanding that led him into allergy.

As a young physician on the staff of Bellevue Hospital, he was called one morning in 1909 to help with a patient who had an acute throat disease and whose breathing came with great effort. While Dr. Cooke held the patient, one of his colleagues forced a tube between the vocal cords and into the windpipe so that air would find an open passageway into the lungs. During this procedure the patient coughed explosively and nearly strangled. The physicians attending him were sprayed with sputum. This was all in the day's work, of course; but, the next day, Cooke was notified that the patient had diphtheria, and that he had better come down and have a shot of diphtheria antitoxin for protection.

He went. Anything was better than getting diphtheria, which then was often fatal. Yet, before he submitted his arm for the shot, a vague thought that had been troubling him became clear. Somewhere he had read of reactions to horse serum; von Pirquet had published something on it. And was there not something also about the relationship between sensitivity to animal dander and the animal serum?

Expressing his misgivings, he was given the

*On Feb. 27, 1958, at the Hotel Pierre, the New York Allergy Society gave a dinner in honor of Robert Anderson Cooke, father of allergy as a medical specialty and founder, 40 years ago, of the first allergy clinic in all the world. Leading allergists from the whole country were present to honor Dr. Cooke as a pioneer, discoverer, and teacher. They presented informal talks, historical in nature, relating to the early days when allergy as an understandable manifestation was just crystallizing.

injection anyway. Before the needle was out of his arm, young Cooke began to feel hot and dizzy. His face and arms began to swell. His breathing began to come in gasps. It was happening! Before he fell to the floor, epinephrine was being injected into him. It was this that saved him. He received innumerable shots of epinephrine and finally the severe symptoms began to wane. For a few days after the episode he was shaken, wan, and unsure.

He had been very near death and the agent that almost killed him was in itself not a poison but harmless horse serum! For a year he read whatever he could find in the literature that related to such mysterious reactions. He read of the work done by Charles Richet, a Frenchman, some 10 years before. Richet wanted to develop an antitoxin against the venom of the Portuguese man-of-war that often stung and at times killed pearl divers. He had collected the venom and in his laboratory injected the venom into a series of dogs. The idea was to stimulate the dogs to produce antivenom in their blood stream. Then, by bleeding the dogs and separating the serum, an agent to protect or to treat the pearl divers would be at hand; but, a certain proportion of his dogs died dramatically after the second injection of venom. This was so curious a phenomenon, he devoted all his time to the study of it and finally could produce it at will. This phenomenon he called anaphylaxis, which means without protection. He explained it as follows: The first injection of poisonous protein (venom) so affected the body that the normal protective mechanism of antibody formation was incapacitated; the following injection of venom, because of its poisonous properties, killed the animal.

However, shortly after this, von Pirquet and Schick, working with diphtheria antitoxin, noted similar deaths in human beings. They believed that, since the diphtheria antitoxin was not in itself poisonous, Richet's postulates as to the mechanism must have been wrong. These men altered the theory of such reactions by saying that the first injection of foreign protein so highly sensitized the organism that the second injection, even if minute, caused the deleterious reactions. But this is as far as these men went. Their ideas dealt only with horse serum. They also postulated that bacteria might sensitize the body and cause trouble when at another time the bacteria appeared in the body.

The literature and the general experience of physicians pointed to human sensitization as the basis for hives occurring after eating certain foods, asthma coming on after contact with certain animals, and hay fever appearing after exposure to certain pollens; but, the true nature of these attacks was not known. The general opinion largely held was that these attacks were based on the "toxic" or generally poisonous nature of the responsible materials. This was given added weight by Richet's postulation of "toxic proteins" despite his coinage of the new word anaphylaxis.

By 1910 Dr. Cooke let it be known at the hospital and among his colleagues that he was interested in studying this entire and strange phenomenon. Hay fever and asthma were the most commonly recognized of these conditions, and slowly such patients were referred to him. Even so, the old records show that in 1912 he saw only 13 patients with hay fever; in 1913 he saw 98; in 1914, 197; and in 1915, 351. In these years he developed methods of testing patients with hay fever and of treating them, as well as methods of collecting pollen and making extracts of the pollen for both testing and treatment. Until then, the usual method of testing was to rub dry pollen or an extract of pollen into a scratch of the skin or to drop a little of it on the conjunctiva. Dr. Cooke evolved the intradermal test; that is the method of testing by injecting a very small amount of pollen extract into the skin.

By 1915 he published a paper on "The Treatment of Hay Fever by Active Immunization" in which the general principles used to this day were laid down. All of this work took place at the old New York Hospital in the new Department of Applied Immunology and Bacteriology headed by Professor Esler.

Gradually, as more patients with a variety of manifestations of allergy were seen, Dr. Cooke realized that elements other than serum, foods, and animals, such as a cat and horse, might be involved. Many Central European immigrants were seen at that time in his department. One day a youngster was brought in from Coney Island. He was having a severe asthma attack, and the story that was told indicated that he had a tremendous amount of difficulty every night. Dr. Cooke and a colleague went out to the child's home after a period of unsuccessful treatment. They found him raised on several pillows having a severe attack. Dr. Cooke ripped the pillows apart and found them stuffed with rabbit hair, which

was common pillow stuffing in Central Europe. The child, rabbit hair-sensitive, was entirely relieved when rabbit hair was eliminated from his environment. This case of rabbit hair sensitivity was the first to be reported in the literature.

The same type of sensitivity was often found among persons from the Mediterranean areas. Only here, the pillow stuffing was made from angora goat hair. Other animal hairs and dander were gradually discovered to be offenders, as were feathers.

In 1917 a young man with severe asthma was sent off to a Southern camp for training. While there, his asthma disappeared; however, when he came home, the asthma returned. Once more Dr. Cooke went to visit the young person's home. He found nothing specific but suggested that floor sweepings be brought in. In testing with the extract of these sweepings, the young man showed a strongly positive reaction. As a matter of fact, the patient suffered from a reaction as severe as the one Dr. Cooke suffered from the diphtheria antitoxin shot. This was the first case of dust sensitivity reported. Since then house dust has been found to be a ubiquitous offender, playing an important pathogenic role in a great many patients with allergy.

By 1918 Dr. Cooke had elaborated most of the ordinary testing materials made from substances that are inhaled. A little later an experience with a patient who had giant hives led him into preparing food-testing extracts. This patient, a woman, had come to see Dr. Cooke because of giant hives, which she believed appeared when she ate blackberries that grew in her front yard. She was asked to bring in some fresh ones. While she waited, an extract was made of these and a small amount was used for the test. Once more, the patient experienced a violent reaction.

In this same year Dr. Cooke opened the doors to his now independent department, the Asthma and Hay Fever Clinic at New York Hospital. This immediately became a very busy clinic and led to the development by Dr. Cooke of the special equipment used by all allergists: syringes of a type with metal plungers and graduated in tenths of a cubic centimeter; syringe trays; improved extracting methods; and improved extracts. More certain and highly involved principles of treatment grew under his leadership as did a more widespread knowledge of allergy.

Gradually, the basic mechanism of allergy was better understood, and Dr. Cooke was able to distinguish between what happened in immunization against infectious diseases and what happened in the protection of the allergic person. This understanding was based on the discovery that there were two types of antibodies involved in allergy: the sensitizing antibody, which attached itself to tissue cells, and which, when combining with the offending agent, resulted in injury to the cell and in allergic symptoms; and the blocking antibody, which floated around in the blood stream and protected the body against the offending substance.

In 1923 Dr. Cooke founded and became the first president of The Society for the Study of Asthma and Allied Conditions. By this time, men who had studied with Dr. Cooke had established their own clinics in New York and in other states as distant as California. The allergist as a medical specialist had appeared. Eventually, this organization merged with a Western allergy organization and in 1944 became the American Academy of Allergy.

In 1933 the New York Hospital was about to move to its magnificent new buildings, and Dr. Cooke took his department, which was now world-renowned and self-sufficient, to Roosevelt Hospital. About four years ago, it moved into the Tower Memorial Building of Roosevelt Hospital, where it occupies a whole floor as the Institute of Allergy.

By 1938 enough allergy clinics existed in New York City (there are 72 now) to cause Dr. Cooke to found the Association of Allergy Clinics of Greater New York, which in time evolved into the New York Allergy Society, with a membership of some 250.

Out of Dr. Cooke's Allergy Clinic have come hundreds of professional articles published in dozens of medical and scientific journals. He has written a large number of these himself and has contributed chapters to many books and systems of medicine. He has also written a standard textbook of allergy, which is in general use today.

Dr. Cooke, now 78 years of age, is director of the Institute of Allergy at Roosevelt Hospital, N. Y. Vigorous, involved in numbers of research projects, and still pioneering new areas, Robert Anderson Cooke is one of the fortunate few who has lived to see his ideas take form and evolve into a great specialty. (Prepared from a release of the New York Allergy Society.)

Letters to the Editor

Every month during my medical school days, I looked forward to receiving the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. Now that I am a resident I look for it just as eagerly.

I have always hoped that perhaps one day I might be able to submit a manuscript to you for publication. Would you please tell me whether residents are eligible to submit a paper to your journal.*

I recently have written a paper on female patients with hirsutism due to different causes. Would it be permissible to send this to you for consideration?

Incidentally, I am deeply grateful to the JOURNAL. Had it not been for an article I read in it one night while I was at medical school I probably would not now be a senior resident in internal medicine. I was out of funds and wondered how I would ever get through school, although I was trying to work at night. I read the President's Message concerning loan funds, wrote requesting a loan, and received it. My repayment is coming slowly, but one day in the future it will be complete.

—M. Jeanne Fairweather, M.D.
Houston, Texas

*They are.

In the April, 1958, issue of the JOURNAL, page 161, the reprint of the abstract on Neutrapen (penicillinase), which originally appeared in *MD Medical Newsmagazine* (2:43, Jan., 1958) contains some statements about Neutrapen which may be somewhat confusing to the average practitioner. In order to anticipate some of the questions that might be raised by these articles, I would like to offer the following information.

Although in some of the original animal work Dr. Chen found that 5,000 units of penicillinase could inactivate 100,000 units of crystalline penicillin, the conditions of this experiment were somewhat different than those which apply in clinical cases. Since penicillinase is virtually nontoxic, we have used a dose of 800,000 units regardless of the amount of penicillin given. Since the usual dose of penicillin varies from several hundred thousand to one and one-half million units, this amount of penicillinase would seem to be the most satisfactory one for all purposes. I assume that when the research for the original article was done, the figures were taken from Dr. Chen's article detailing the results in his rabbit studies.

It seemed to me from reading the abstract that Neutrapen was roughly classified with steroids and antihistamines. I would like to point out that Neutrapen is a specific drug, whereas the others are symptomatic remedies. Neutrapen specifically destroys penicillin, the allergen in penicillin reactions. It is, then, the first specific for these unfortunate conditions and is clearly indicated in every instance. Steroids and antihistamines, on the other hand, may or may not be used depending upon the conditions of each independent case.

If there are any other questions that you or your readers may have relating to Neutrapen, I will be more than happy to discuss them with you. If there is anything else I can do for you, please do not hesitate to let me know.

—B. Marr Lanman, M.D.
Director of Clinical Research
Shenlabs Pharmaceuticals, Inc.

Medical Briefs

DIGITALIS AND EPINEPHRINE COMBINATION IN HYPOTHERMIA

Instead of stimulating the heart as it ordinarily does, epinephrine has been found to depress the heart when used in combination with digitalis, and when body temperatures are lowered by hypothermia.

Surgeon Theodore Cooper and pharmacologist Marion Cotton of the Public Health Service's National Heart Institute at Bethesda, Md., have found that the cardiac stimulant effects of epinephrine and four of its close chemical relatives (norepinephrine, isoproterenol, ephedrine, and phenylephrine) were either blocked or reversed by two digitalis compounds (ouabain and digoxin) in dogs whose body temperatures had been reduced 15 degrees below normal.

At normal body temperatures the cardiac stimulant effects of the epinephrine-like drugs were not affected by the digitalis, but, as the temperatures of digitalis-treated animals were lowered, the effects of the epinephrine-like drugs were blocked, and at 86 F the drugs actually caused a measurable decrease in the force of heart muscle contractions.

Treating those patients who have heart disease with digitalis before lowering their body temperature for surgery has been shown to prevent the heart failure that is a major threat in heart operations in which hypothermia is used. Consequently, treating the candidate for heart surgery with digitalis before operation has become a common safety practice in some clinics, as in the Heart Institute Clinic of Surgery. The epinephrine-like drugs, because they normally constrict arteries and raise blood pressure, are also commonly used in low blood pressure emergencies such as shock, which sometimes develop during surgery.

The new findings, Dr. Cooper explains, have thus revealed a potential but avoidable hazard for the patient undergoing cardiac surgery under hypothermia.

Preliminary studies with methoxamine, a drug that raises blood pressure and that is different in chemical structure from the five others studied, indicate that it is not blocked by the digitalis compounds. More research is needed to determine the performance of various drugs and combinations of drugs under conditions of hypothermia, Dr. Cooper said.

GONORRHEA

Gonorrhea continues its downward trend to 216,476 cases reported in 1957, as against 233,333 in 1956 and 239,787 in 1955, although it should be noted that the reporting of gonorrhea is especially spotty, and that the incidence of this disease may be anywhere from 3 to 10 times the number of cases actually reported. This fact was reported in the fifth Annual Joint Statement, "Today's VD Control Problem," based on a nationwide survey conducted jointly by the American Social Hygiene Association, the Association of State and Territorial Health Officers, and the American Venereal Disease Association.

Although 14 states and 19 cities noted a rise in VD in the 11-19 age group, 29 states and 49 cities observed no change in teen-age statistics. One state, one territory, and six cities noted a decline in teen-age VD. Four states and 23 cities either had no data available for this age group or their comments indicated no particular trend.

Health officials believe the increase in total cases of syphilis represents better case-finding and better employment by state and local governments of the tools of control. They are hopeful that present program resources may be added to and maintained at a reasonably high level in order to re-establish the rapid decline in syphilis and gonorrhea that characterized the late 1940's and early 1950's.

The biggest problem to health officers is the shortage of personnel to maintain adequate coverage of the VD problem. Thirty-two states, one territory, and nine cities report inadequate coverage in a total of 137 areas with a combined population of about 20 million.

Personnel shortages were reported by 28 states, 2 territories, and 12 cities. They estimated that, in order to provide adequate coverage, they would need 35 additional physicians, 53 additional nurses, 87 additional investigators, 6 additional laboratory technicians, 15 additional record analysts, and 27 additional health educators.

World Health Organization

SAFER CHILDBIRTH

In some of the 28 countries and territories covered by the Epidemiological and Vital Statistics Report, vol. II, no. 3, mortality from complications of pregnancy and childbirth dropped almost 50 per cent between 1950 and 1956. Among the countries reporting rates for 1956, Denmark had the lowest (48.2 per 100,000 live births) and Ceylon the highest (376.5). In Israel (Jewish population) the rate was 48.4; in Scotland, 53.5; in France, 55.3; in Australia, 56.1; in England and Wales, 57; in Northern Ireland, 57.6; in Canada, 61.7; in The Netherlands, 67; in Ireland, 85.6; in Finland, 111.4; and in Austria, 121.7.

In the following countries, the latest rates given are for 1955: New Zealand, 44.1; United States, 47; Sweden, 49.4; Norway, 67.7; Belgium, 80.4; and Switzerland, 104.3.

ANTIVIRUS ARMAMENTS

There are four different ways in which viruses can be kept in check and can be even conquered.

1. The human body builds its own natural resistance to virus infection in the form of antibodies. When invaded by any one of the three poliomyelitis viruses, for instance, the body itself produces the appropriate antibodies enabling it to neutralize the destructive action of that particular virus. Thus a mild infection in childhood will provide the human organism with a lifelong protection against that particular virus, although not against the other two. With improved sanitation and better living conditions, however, children are less likely to contract such mild and "protective" infections in their early years, and in the more advanced countries large sectors of the population now find themselves without any such "natural" protection against the polioviruses and their ability to attack the nervous system and produce paralysis.

2. Medical science can now produce vaccines to protect against many of the most serious virus infections, such as poliomyelitis, yellow fever, typhus, smallpox, influenza, mumps, and certain of the encephalitis diseases. Against jaundice and measles, physicians now are able to use injections of gamma globulin, given as quickly as possible after exposure to infection.

3. The insects that carry viruses, such as the yellow fever mosquito and the typhus louse, can be destroyed with modern insecticides. Careful control of airplanes, ships, and other international transport can prevent infected travelers or insects from reintroducing the virus into regions that have been cleared of it.

4. Antibiotic drugs have proved effective against infections such as trachoma and conjunctivitis.

MEDICAL CARE

There are now 1,236,000 physicians serving the world's 2.7 billion inhabitants, and the 638 medical schools operating in 85 countries graduate annually about 67,000 new doctors.

There are 14 countries fortunate enough to have one doctor to serve every thousand or fewer people. But there are 22 others where there is only one doctor for 20,000 or more inhabitants. Between these two extremes, the rest of the world shows great variations.

As a general rule, there is a shortage in rural areas, while cities may have an overabundance of medical practitioners.

While 9 countries have one medical school for less than 1 million of population, there are 13 countries with only one such school for 9 to 17 million people.

President's Message

As you read the September issue of the JOURNAL, you may be making your plans to attend the Midyear Meeting of the Board of Directors, to be held at the Woodner Hotel in Washington, D.C., on Nov. 13-16. If your plans are not yet made, or are only tentative, it is hoped that the excellent program, including stimulating panel discussions as well as interesting sight-seeing trips in our Capitol, will attract you.

Of course, there is business to be accomplished; but, with our more efficiently functioning committees, the time spent on that is minimized. However, if we are to fulfill our function, we do need representation through an official delegate, as well as other members, from every one of the branches in our organization. At this time, especially, there is a need for greater interchange of ideas between branches and the general Association. To accomplish this, your "gripes" will not be overlooked, but your constructive suggestions will be more appreciated. It is well known that, in any organization, the attitudes of the membership throughout the country must be understood and appreciated before any plan can be successful. Our plan for the American Medical Women's Association at this time is not only to maintain the splendid work of the various standing committees but to emphasize the theme for the year's program, "The Physician in the Role of Adviser," which will be featured again at the Midyear Meeting and which the branches will be encouraged to follow throughout the year.

Program development is found important in many organizations. To quote Dr. Robert H. Felix, Director of the National Institute of Mental Health (*Welfare Bulletin* of Illinois Department of Public Welfare, April-May-June, 1957), "The most common requests from the States are for consultation on program development; recruitment and training of personnel; methods of implementing mental health service, such as outpatient clinics for emotionally disturbed and mentally retarded children and adults; improvement of treatment, rehabilitative, and aftercare programs; and public education." As you see, program development is the first item listed for consultative suggestions, and it seems to me that we need more of this attitude in our organization. I mean that the branches should request consultation from the general Association in regard to program planning and, in a reciprocal manner, send suggestions for program material. A beginning was made in this direction when, in 1956, Dr. Kahler, then President-Elect, circulated a questionnaire in regard to emotional health in the family. Some very good data were obtained in this way. Perhaps, we need more of this.

These are rapidly changing times, and we all must learn to change with them. Since change is required for growth, let us expect it and prepare ourselves by maintaining flexibility of thinking and an open-minded attitude. We must all, it seems to me, assume some responsibility for meeting this challenge. "Accepting responsibility," according to Miss Kathryn G. Hansen (*The University Woman*, Dec., 1957), "is a very straightforward thing. You do, or you don't. If you really accept responsibility, you will be willing to stand up and be counted. You can't accept [*the appointment*] and not accept responsibility. This applies whether your responsibility is for a lowly committee assignment or for a top flight position." Although it is a little harsh, I like this concept of responsibility and would like to see it applied at this time. I do hope, then, that I can count on each one of you to accept some degree of responsibility for the growth and development of the AMWA.

Katharine W. Wright

The Minutes of the 1958 Annual Meeting will appear in the October JOURNAL

PROGRAM

1958 MIDYEAR MEETING

American Medical Women's Association, Inc.

Woodner Hotel
Washington, D.C. *November 13-16, 1958*

Thursday, November 13

9:00 a.m.—Executive Committee Meeting

11:00 a.m.—Publications Committee Meeting

1:00 p.m.—Finance Committee Meeting

3:00 p.m.—1959-1960 Program Planning Meeting

3:00 p.m.—Editorial Board Meeting

7:30 p.m.—Executive Committee Meeting

Other Committee Meetings as Scheduled by the Chairmen

Friday, November 14

8:30 a.m.—Business Session

10:30 a.m.—Buses Leave for Tour of National Health Institutes

1:00 p.m.—Luncheon at Institutes

2:00 p.m.—Speaker from Institutes To Be Announced

7:30 p.m.—Dinner. Speaker To Be Announced

Saturday. November 15

9:00 a.m.—Business Session

12:30 p.m.—Luncheon: Panel

6:00 p.m.—Hospitality Hour

7:00 p.m.—International Night Dinner. Report from MWIA 1958 Congress. Reports on Visit of Women Physicians to Russia. Presentation of Awards

Sunday, November 16

9:00 a.m.—Business Session

12:30 p.m.—Luncheon Panel

2:30 p.m.—Marine Band Concert.

For Room Reservations, see advertising page 18; For Meal Reservations, advertising page 22.

SPECIAL ARTICLE

New York Homestead Plan

NEW YORK CITY'S HOMESTEAD program for the care of the chronically ill and elderly at the Goldwater Memorial Hospital was officially launched on March 14, 1958, by Mayor Robert F. Wagner, Hospitals Commissioner, Dr. Morris Jacobs, and Dr. Howard A. Rusk, international authority on physical medicine and rehabilitation. Studies, financed by grants provided through the New York Foundation to the American Hospital Association and the United States Department of Health, Education, and Welfare, are expected to set a country-wide pattern for more effective and economic care of the chronically disabled, requiring minimal medical and nursing care.

The homestead plan developed from the Public Home Infirmary Program, conducted in co-operation with the State Department of Social Welfare and the New York City Department of Welfare, which determines eligibility to receive public assistance. This new approach in caring for the chronically ill and elderly adds minimal recreational rehabilitation services to such medical and nursing care as is needed.

The Goldwater program started on July 1, 1953, when a geriatrics rehabilitation service was established as a joint project of the New York University-Bellevue Medical Center and the Department of Hospitals through a special grant of the New York Foundation. In 1949 Dr. Eli Ginsberg had reported: "The municipal hospitals of the City of New York are overcrowded because they are unable to transfer chronic patients to other suitable facilities. This situation obtains even in Goldwater Memorial Hospital, which was established (1939) as a specialized hospital for the active treatment of patients with long-term illnesses but whose patient population has become increasingly composed of individuals requiring custodial care. . . ."

The Goldwater study announced by Dr. Rusk in 1954 revealed that, of 95 unselected custodial patients whose average age was 68.5 years, only 7 were felt to be in need of continued hospitalization, with two of these considered questionable. As a result of the study it was reported to Mayor Wagner in October, 1956, that "1 out of every 5 patients in the city's municipal general and chronic disease hospitals is there not because he needs hospital services but simply because he or she has no other place to go." This study also resulted in a recommendation for the establishment of homestead facilities, utilizing existing general care and chronic disease hospitals but with special provisions for the comfort and recreational and rehabilitative needs of the patients, mostly elderly men and women.

Of the patients interviewed during the study, 19.2 per cent no longer required hospital care but could not be discharged for lack of community resources to care for them. There were between 1,740 and 2,200 such patients in the more than 10,000 beds surveyed. These patients suffered primarily from neurological conditions, cardiovascular diseases, and arthritis. After completion of intensive medical care and rehabilitation, they were still restricted in activity. Some had no home or relatives, and others were too disabled to return to a home environment. The institutions that might have met their requirements for bedside care and assistance in activities of daily living and social functions did not exist in sufficient numbers to relieve the hospitals of this burden. Age and chronic disease had resulted in unemployability, and these and other factors noted in the survey brought these patients to a state of medical indigency, which compelled their admission to City hospitals. Dr. Rusk said that a steady rise in the number of these patients could be expected.

"The study required an evaluation of the patients in the hospitals rather than an analysis of patients' records on discharge. A 20 per cent stratified random sample of the patients in each hospital, at a given moment in time, was studied by a field team. Obstetric and newborn infant wards were omitted on the assumption that they presented no chronic disease problems, while tuberculosis and psy-

chiatric wards were excluded because of the different disposition facilities used for these patients." Among the pressing needs highlighted by the mass of statistical data collected in the survey were: the necessity for a more precise separation of the patients in municipal hospitals into acutely ill, chronically ill, and custodial categories; and the development of distinct facilities for the care of each of them, along with expansion of the rehabilitation and home care programs.

The Public Home Infirmary Care program began at Goldwater on Aug. 19, 1957, for 90 patients. Additional wards have been opened and 36 beds now are being utilized. The expanded rehabilitation services, under the guidance of Dr. Rusk, have now been established in seven institutions totaling 831 beds, with two more units planned, to bring the total beds to 1,000.

PHIC beds in the municipal system total 1,864 at the Bird S. Coler Memorial Hospital and Home on Welfare Island, Farm Colony on Staten Island, Elmhurst General in Queens, and at Goldwater. Additional units will be provided at Queens General, Bellevue, the Bronx Municipal Hospital Center, and at Coney Island in Brooklyn. By late 1958 or early 1959 a total of 3,500 PHIC beds will be provided within the municipal compound of slightly more than 20,000 beds, with the research findings of the Goldwater project utilized to convert as many as possible, and as quickly as possible, to homestead areas.

Because of its deep interest in the national implications of the homestead project, the Hospital Research and Educational Trust, an affiliate of the American Hospital Association, has received two grants to conduct research programs relating to the homestead program and to disseminate the findings of their studies to hospitals throughout the United States. The first grant, supplied by the New York Foundation ($25,000 a year for two years), will be used to study the homestead program and to develop a series of recommendations regarding the professional, administrative, and financial factors involved in starting domiciliary units such as the homesteads, so that these recommendations can be used as a blueprint by other communities in starting their own homesteads. A particularly interesting economic factor is that there is better than 50 per cent reimbursement through the state and federal governments for this infirmary or homestead care, which costs about $8.50 per patient day, compared to $25 a day in an acute general hospital facility.

The second and related research project is being conducted by the Hospital and Research and Educational Trust on a grant from the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare, Washington, D.C. This will be a five year research project aimed at developing evaluation procedures that easily can be applied to long-term patients to determine their need for continuing hospital services. An evaluation team consisting of physicians, physical therapists, occupational therapists, social workers, and speech and hearing therapists will be established at Goldwater Memorial Hospital to evaluate patients under consideration for transfer from Goldwater Memorial Hospital to the Goldwater Homestead. When the evaluation procedures have been developed and tested through experience, they then will be applied to all persons being considered for admission to the homesteads operated by the Department of Hospitals, in order that the validity of the evaluation criteria and procedures may be firmly established and that no changes in methodology dictated by experience may be made. Dr. Rusk will serve as the director of both projects on behalf of the Hospital Research and Educational Trust.

Dr. Rusk has said: "We hope that these studies at Goldwater may show the rest of the nation how to care most effectively and economically for the increasing number of chronically disabled, the great majority of whom are elderly people with permanent and often static physical disabilities, who require medical and hospital care only occasionally. This group, . . . since they do not need as much care as actively ill patients, receive less attention in hospitals and inevitably feel neglected and rejected. The very nature of the hospital, whose primary purpose is to provide definitive care to the actively ill, means that the basic needs of the chronically disabled (affection, emotional security, education, spiritual development, social contacts, opportunities for self-expression through creative activity, and the assurance of being regarded as an individual) often go unmet due to the pressure on the staff to provide acute care first. Over and above this, the chronically disabled in hospitals are forced to live for months or years in an environment in which pain and death are a part of the daily routine."

Of Special Interest

INCOME TAX RULING

The Department of Internal Revenue has ruled that physicians in full-time employ of hospitals may indorse to the hospital checks received from patients who insist upon paying the physicians instead of the hospital, and thus be excused from including the sums as income. A schedule must be attached to the tax return indicating the sources of the fees, amounts received, and disposition thereof.

RESIDENCY DEFERMENT PLAN

The Department of Defense has requested the lists of 1958 graduates from medical school deans in order to find out the number who are interested in draft deferment while taking residency training next year. The U.S. Armed Services will have 67 residencies in pediatrics, 56 in surgery, 44 in obstetrics and gynecology, 32 in radiology, 16 in urology, and 7 in ophthalmology.

In July, 1958, about 900 draft-eligible 1957 graduates will start specialty training under the Berry Program. One hundred per cent of the applicants for the following specialties were accepted: otolaryngology, general practice, anesthesiology, occupational medicine, pathology, preventive medicine, and physical medicine. Ninety-eight per cent of psychiatry applicants were accepted, and, from there, acceptance ranged downward from 84 per cent in neurology to 33 per cent in neurosurgery and 28 per cent in internal medicine.

EMOTIONAL PROBLEMS OF CHILDHOOD

A series of nine weekly talks on "Emotional Problems of Childhood" have been presented at the North Shore Hospital, Winnetka, Ill. The series will be published in book form, and all royalties have been assigned by the Hospital to the American Psychiatric Association. The texts, by leading authorities on psychiatry, are said to be "invaluable for the working knowledge of every physician who wishes to treat the whole patient."

The Ninth Fall series will begin in October, 1958. The theme will be "Emotional Forces in the Family" and will be under the direction of Dr. Samuel Liebman, Medical Director, North Shore Hospital.

LEGISLATION

H.R. 12331 proposed by Rep. Knutson (D., Minn.), would appropriate $200,000 for research by the National Institutes of Health in cystic fibrosis. The surgeon general of the Public Health Service would be authorized to recruit and train individuals to conduct research in this field.

INSURANCE FOR OLDER CITIZENS

The Health Insurance Association of America at a meeting in Chicago in May considered ways and means of keeping the American public fully informed of progress in solving such social problems as the "financing of health care for the older aged." It was noted that the insurance business is making "great strides" toward accident and sickness coverage for the senior citizens. Accident and health coverage by companies for retired employees and more individual coverage renewable for life were cited as examples of progress. Support of the Forand Bill by labor and other groups is considered an indication of public opinion on the subject of adequate provision for this group of citizens.

In order to provide more knowledge for both the insurance business and supporters of the Forand Bill, several new studies have been undertaken by government and private agencies, including the Social Security Agency, the Health Information Foundation, and the American Hospital Association. The results of these studies should provide a better basis for evaluating and resolving the problem.

Rising claim ratios and overutilization of hospital facilities are other problems to be mutually solved by the health care field and the insurance business. Voluntary insurance in order to survive must operate on a sound business basis, yet management must keep in mind that it is the custodian of public funds and should have an awareness of the trusteeship involved. It was also pointed out that, to a large degree, the medical and hospital professions control, and can prevent, overutilization of hospital facilities.

The conviction was expressed that the majority of medical and hospital personnel recognize their responsibility and desire to cooperate in order to use medical expense plans

as they were intended and to prevent inflating of the cost of medical care. The insurance companies were urged to look at the problems in terms of meeting the needs of the public not in terms of profit above all else.

MORE NURSING HOMES URGED FOR 1959

The Georgia Department of Public Health is urging a speedup of the construction of nursing homes for the aged and for patients with long-term chronic illnesses. The Department's plans for medical and hospital facility construction have been approved by a special session of the State Board of Health. The plans will now be submitted to the U.S. Public Health Service for approval in conformity with requirements of the 1946 Hill Burton Act and the Medical Facilities Act of 1954. A survey made this spring showed that Georgia has only 8 per cent of the chronic hospital beds needed and only 21 per cent of the nursing home beds needed. Construction of nursing homes will have high priority. This program is designated as a "joint state, federal, and community-type program with a minimum of federal and state control."

TRAINING FOR ASIAN PHYSICIANS

According to an announcement from the Australian Association of Pathologists, if an agreement is reached with universities, hospitals, and administrative authorities in Malaya and Singapore, Colombo Plan–sponsored training of Asian doctors in infant pathology might begin at Royal Children's Hospital in Melbourne within a year.

DAKAR MEDICAL SCHOOL

The University of Dakar, French West Africa, officially opened in September, 1957, with a National School of Medicine and Pharmacy, a Faculty of Science, a Faculty of Law, and a Faculty of Liberal Arts. The foundations for higher education were laid in 1949. Seeing the desirability of locally trained doctors, urgently needed by the overseas population, the French first established the Medical and Pharmaceutical Preparatory School.

The Medical and Pharmaceutical Preparatory School, now the National School of Medicine and Pharmacy, will become the Faculty of Medicine of Dakar University as soon as enough qualified professors, especially Africans, can be recruited by competitive examination. In the meantime, the program covers the first three years of medical studies and includes studies in dentistry and pharmacy. African medical students can acquire practical experience locally through junior internships at Le Dantec Hospital in Dakar. A new hospital for the University is planned in order to meet the expected increase in the number of interns. Students have increased from 1 in 1948-1949 to 116 in 1957-1958.

OFFICE MANAGEMENT CONFERENCE FOR STUDENTS

The San Francisco Medical Society held a half-day symposium on Office Management and Public Relations on April 13 for the Stanford and University of California medical students. How to stay on one's feet financially during the first year of practice is of great concern to most students. Economic trends in medicine, financing and choosing a practice, third party medicine, and the physician's role in the courtroom were subjects covered.

"Financing the New Practice," a 30 minute film strip that deals with Drs. Newcomer, Young, and Hope, each starting out in a different type of practice, and the problems they encounter trying to make ends meet, may be obtained from the Director of Professional Relations, Mead Johnson and Company, Evansville 21, Ind., for use in a comparable symposium.

MEDICAL EDUCATION

The Second World Conference on Medical Education, scheduled to convene in Chicago, Aug. 30-Sept. 4, 1959, will have as the theme "Medicine–A Lifelong Study." The 1953 London Conference discussed "Undergraduate Medical Education." The scope of the program will include specialist training and the development of teachers and investigators and means by which the practitioner can avail himself of the newest findings for use in the medical care of patients.

Approximately 100 invited speakers from more than 50 countries will present papers at the Conference. Simultaneous translations in English, Spanish, and French will facilitate the discussions of the world's leading medical educators, investigators, and practitioners as they consider the problems, programs, and standards of advanced medical education.

MEDICAL ECONOMICS

"The Doctor and His Practice" was the theme for a forum held in Washington, D.C.,

under the sponsorship of the Medical Council of the Washington (D.C.) Metropolitan Area and William S. Merrell Company. Experts on law, management, and finance spoke at the one-day short course.

NEWS OF WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA

Under the will of Dr. Margaret A. Warlow, class of 1902, the Woman's Medical College has received a bequest of $71,242. It is an unrestricted gift. Dr. Warlow was especially interested in research.

The College also has received a grant of $5,000 from the Smith, Kline and French Foundation, to be used for research by Dr. Sydney Ellis, Professor of Pharmacology. The funds will be used in part to purchase the necessary equipment to develop a laboratory for the study of the electrophysiological aspects of the action of drugs.

Another grant of $5,900 has been made to the College by the National Science Foundation for support of research entitled "Population Dynamics of Linked Chromosomal Varients," to be used over a three year period by Dr. Max Levitan, Assistant Professor of Anatomy at the College.

Plans for a new 2 million dollar wing to be constructed, starting in the fall of 1958, has been announced by the Chairman of the Board of Corporators of The Woman's Medical College of Pennsylvania. The wing will consist of six stories and basement and is designed principally for research. One floor will be used for administrative facilities, a second floor for the Department of Physiological Chemistry, and the remaining floors for basic clinical research. Diagnostic and treatment facilities are included in the over-all plans.

The research floors were made possible by matching a $500,000 grant from the U. S. Public Health Service, given to the College for laboratories. Funds are still needed to complete the 2 million dollar goal needed to include the teaching and diagnostic facilities.

The new wing with the expanded Department of Physiological Chemistry will make possible enrollment of 20 per cent more freshmen students each year.

THESE WERE THE FIRST

Dr. Margaret Ellen Holland graduated from the Woman's Medical College of Chicago in 1871, and was the first woman physician to practice in Harris County, Texas. Dr. Holland and born in Newberryport, Mass., in 1840 and came with her family to Kansas by the prairie schooner route. She was active in civic work in Houston, and, although she had no children of her own, she educated four young people and was known for her philanthropic work. Dr. Holland died in August, 1921.

Dr. Helen Johnston, Columbus City, Iowa, graduated from Cornell Unversity Medical College in 1919, and practiced in Des Moines, Iowa, from 1920 through 1923. She was the first woman examining physician for the Des Moines Public Schools. In 1929 she was president of the International Association of Altrusa Clubs and in 1944 president of the American Medical Women's Association.

Dr. Maria K. Korchagina of Moscow, Russia, was the only woman physician and surgeon to an army of 5,000 Russian Cossacks during World War I. When this army joined the British she reached Mesopotamia and was decorated with the Cross of St. George for her work with the refugees. When the Bolsheviks took over, she escaped to the Isle of Lennos and from there went to the American Hospital for Women and Children in Madura, India. In 1935, when she visited this country, Dr. Korchagina was in charge of the Satara Friendship Center in Madura.

Dr. Ann Purdy of Waterloo, Quebec, Canada (born in 1888), graduated from Johns Hopkins University Medical School in 1919 and in 1921 married Dr. Emile Holman, settling in San Francisco. Dr. Purdy was in charge of the Children's Cardiac Clinic at Stanford and at Children's Hospital, and was the first woman to be chairman of the San Francisco Heart Association (1950). Dr. Purdy, now retired, was also clinical professor of pediatrics at Stanford University School of Medicine.

—From the Elizabeth Bass Collection,
Rudolph Matas Medical Library,
Tulane University, New Orleans.

Opportunities for Women in Medicine

COURSES

Obstetrics. The Woman's Hospital in New York City is offering two courses in obstetrics, limited to general practitioners. Each course is approved for 30 hours Category I credit by the American Academy of General Practice. The courses are Ante-Partum Care and Conduct of Labor and Delivery. They will be given Oct. 16-30. These are full-time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected. Write to Mr. Carl P. Wright, Jr., Woman's Hospital, 141 W. 109th St., New York City 25, and an application blank and prospectus will be forwarded.

MEETINGS

Anesthesiology. The Biennial Western Conference on Anesthesiology will be held at the Westward Ho Hotel, Phoenix, Ariz., April 1-4, 1959. "The Heart and Anesthesia" will be the Conference theme.

Cancer. The American Cancer Society will present a Symposium on Carcinoma of the Colon and Rectum at the Annual Scientific Sessions, Oct. 20-21, 1958, at the Biltmore Hotel, New York City.

Gastroenterology. The 23rd Annual Convention of the American College of Gastroenterology will be held at the Jung Hotel in New Orleans Oct. 20-22, 1958, and will be followed by the Annual Course in Postgraduate Gastroenterology. A one-day regional meeting at the University Hospital in Mexico City on Oct. 27, 1958, where members of the College from that city will present papers, is included in this year's session. For the program and information write to: American College of Gastroenterology, 33 W. 60th St., New York City 23.

Occupational Health. The Thirteenth International Congress on Occupational Health will be held in New York City during July, 1960. The theme for the Congress will be "prevention rather than cure of occupational injury and disease." Physicians, nurses, industrial hygienists, and delegates from 40 countries will attend and report on their experiences, findings of both clinics, laboratory research, and on methods of control of occupational health hazards. The Congress will emphasize the fact that the science of health knows no national boundaries.

Sixth White House Conference on Children and Youth. This conference will be held in March, 1960, on the directive of President Dwight D. Eisenhower to the Honorable Marion B. Folsom, Secretary of Health, Education, and Welfare, which was issued at the White House, May 27, 1958. "It is my desire that all private and public groups and organizations concerned with this field have maximum opportunity to participate." A national advisory committee appointed by the President will select the theme for the conference and will assume responsibility for its direction.

State governors have been invited by Secretary Folsom to appoint special committees for a national state-by-state stock-taking on problems of children and youths. These committees will serve as liaison groups between the states and the over-all national advisory committee appointed by the President. It is hoped that the states will use the pre-Conference planning to see how far they have come in the last decade and where they should go in meeting the needs of their children.

Such conferences have been held every 10 years since the first one was convened in 1909 by President Theodore Roosevelt.

U. S. GOVERNMENT AWARDS

U.S. Government Awards Under the Fulbright and Smith-Mundt Acts. The committee will be glad to receive inquiries concerning openings still available and will accept applications until the panels are complete. The closing date for applications is Oct. 1, 1958. Send inquiries to Conference Board of Associated Research Council's Committee on International Exchange of Persons, 2101 Constitution Ave., Washington 25, D.C.

BELGIUM AND LUXEMBURG: 1. One one-semester award in medicine and related fields is available at the University of Liège. A geneticist who would assist the Faculty of Medicine in establishing a new Centre de Génétique is desired. 2. One one-semester award in medicine is available at the University of Brussels (the Institut Bordet). First choice would be given to a biochemist or biologist, preferably with experience in purification of proteins and/or hormones, to participate in research on the concentration and tests of substances inhibiting growth, and possibly the growth of tumors. Assignment would be with the Cytology and Experimental Cancerology Laboratory of the Institut Bordet.

DENMARK: One award in biological sciences for a candidate in nutrition and endocrinology is available in the Department of Biochemistry and Nutrition of the Technical University of Denmark.

FRANCE: One award in medicine, pharmacy, and related fields is available. There are many opportunities in the area of medical and related sciences.

ICELAND: A lecturer in morbid pathology or immunology is needed at the University of Iceland from October through the second week in May, 1959.

IRAN: Awards in science and medicine at Tehran University Medical Faculty and Shiraz University Medical Faculty are available for two lecturers who are professors in biochemistry and physiology. Six hours per week are to be given to these assignments. Shiraz requests a specialist in one of the following: public health administration, bacteriology, pharmacology, or laboratory techniques. The University is developing its medical faculty into a center of modern medical education.

ITALY: An award in clinical psychology and medicine is available for study of prison inmates from the psychological and neuropsychiatric point of view, in order to develop pedagogic rehabilitative medicine. This research is sponsored by the Institute of Criminology of the University of Rome and a special government agency, the Italian National Observation Center, which has excellent facilities. 2. There are two awards in basic science in which research possibilities are almost limitless; for example, research in embryology and biological chemistry; research in hemoglobin variants, in haptoglobins, in the genetics of favism, and in human population genetics; research in hematology, particularly in blood coagulation and hemorrhagic diseases; and lecturing on medical utilization of radioisotopes.

THE NETHERLANDS: An award is being offered in medical science at the State University of Groningen, with cardiology, endocrinology, or pediatrics the preferred specialties.

NORWAY: 1. An award in biological sciences (thrombosis research) is being offered at the University of Oslo's Institute for Thrombosis Research for collaboration in research already underway on the mechanism of the coagulation process, functions of blood platelets, and causes of arterial thrombosis. Research is also being carried out on hemostasis and various hemophilic conditions. 2. There is an opening in cancer research at the Norwegian Hydros Institute for Cancer Research. The person would work in close relationship with the University of Oslo and the Norwegian Radium Hospital. The research program is based on the primary problems of the Hospital and the Institute as centers for radiation therapy. Interest is concentrated on the biological effects and the physical properties of various kinds of radiation, and on the effects of radioprotective substances. Preferences would be given to a scholar who wishes to work in the Department of Biophysics in radiation biophysics, medical radiation physics, or radiation physics.

News of Women in Medicine

DR. MARY B. ARNOLD, as principal investigator in a research project at the University of North Carolina School of Medicine, Chapel Hill, will attempt to develop a new biological method for analyzing activity of the parathyroid hormone in relation to the action of the glands in metabolic bone disease. She will also work with Dr. J. Franklin Williams in studying the effect of vitamin D on phosphate excretion. The study has been made possible through a grant by the Easter Seal Research Foundation.

DRS. GENEVIEVE BADER and Michael Jordon spoke on "Gynecologic Cancer and Its Precursors" at a meeting of the Academy of General Practice, New York City Cancer Committee, on June 12. The general topic was "The Diagnosis and Management of Early Cancer in the General Office."

DR. KATHARINE BAIN was appointed Deputy Chief of the Children's Bureau, U.S. Department of Health, Education, and Welfare. Dr. Bain, a long-time member of the Children's Bureau staff, and a former practicing pediatrician, will now assist in initiating and formulating broad program emphases, policies, and positions on matters affecting children and childlife.

Dr. Bain was assistant to the Bureau Chief for Program Development. In 1956-1957 she assisted, at the request of the National Bureau of Standards, in designing a study to determine the reaction of young children to conditions simulating entrapment in refrigerators or iceboxes. The findings of this study provided the basis for standards for release devices required by Public Law 930.

In 1956 she visited eight countries of the Middle East and Southeast Asia, observing programs aided by UNICEF. She served as adviser on the U.S. Delegation to the Seventh Session of the Regional Committee for the Western Pacific of the World Health Organization. Beginning in 1957, she has served as special adviser to the U.S. Delegation to the Executive Board of UNICEF.

Dr. Bain, from 1945 through 1947, was a member of the Executive Staff that designed and made the first nationwide survey on the extent of health services for children in this country. This study was undertaken by the American Academy of Pediatrics, with the assistance of the Public Health Service and the Children's Bureau.

During the war, Dr. Bain helped in civil defense planning, with emphasis on evacuation of children, day care of children of working mothers, planning for materials in scarce supply, and feeding in occupied countries. She was a member of the Technical Secretariat, United Nations Conference on Food and Agriculture, held in Hot Springs, Ark., in 1943.

Under Dr. Bain's guidance, the Clearinghouse for Research in Child Life was established in the Children's Bureau in 1949. It is a center of information on research in universities and other centers throughout the nation.

Born in St. Louis, Dr. Bain was graduated from the University of Missouri in 1920, and received her M.D. from Washington University in 1925. She trained in the San Francisco Children's Hospital and the St. Louis Children's Hospital, and has served on the teaching staff of the Washington University School of Medicine and the St. Louis Children's Hospital. She began pediatric practice in St. Louis in 1927.

DR. RUTH BAKWIN, New York City, represented the AMWA at the first Asian Pediatric Congress in Singapore on May 26-30, 1958.

DR. LEONA BAUMGARTNER and DR. MARY S. CALDERONE, both of New York City, were elected members of the Board of Directors of the National Health Council.

DR. VIRGINIA COBB is chairman of the Advisory Committee to the University of Arizona Poison Control Information Center.

DR. ELIZABETH COMSTOCK was cited in the May, 1958, *Wisconsin Medical Journal* (Section on Medical History) for her own historic background, for her years of active service as a member of the Section on Medical History, and for numerous contributions to the Section, many of which will be given to

the Medical Museum of Wisconsin, to be built in Prairie du Chien. Dr. Comstock was the second woman physician initiated into the State Medical Society's 50 Year Club. The late Dr. Mina B. Glasier of Bloomington was the first woman to have this distinction.

Dr. Elizabeth F. Constantine participated in the program of the New York Academy of Medicine, Section on Ophthalmology, April 21, speaking on "Problems in Monocular Aphakia."

Dr. Ruth J. Guttman of the Francis Delafield Hospital in New York gave a paper on "Irradiation Treatment of Cancer of the Cervix" at a meeting of the Bronx Gynecological and Obstetrical Society, Inc., on April 21.

One June 8 Alma Louise Higgins, Peabody, Mass., received her B.S. degree at Boston University. A unique graduate program has been arranged for her at the University, which will combine journalism and medical courses. She will be the first journalism student at Boston University to do a thesis in this field. She will take courses in public health, preventive medicine, medical law, and history of science at Harvard or Boston University medical schools. She is the daughter of Dr. and Mrs. Walter D. Higgins of Peabody.

Dr. Mary Ethel Lane, Montefiore Hospital, New York, presented a paper on "Hypertension in Pregnancy" at the Grasslands Hospital, Valhalla, on April 29.

Dr. Jane Lin spoke on "Chronic Hypoglycemia with an Epileptic Syndrome," and Dr. Anita Carreon spoke on "Meconium Plug Syndrome" at a meeting of the Brooklyn Academy of Pediatrics on April 23.

Dr. Alvina Looram of Santa Fe, N. Mex., was quoted in *Scope Weekly* in the reply to the question, "What medical development in the past five years do you feel was most helpful to the general practitioner," as saying, ". . . the development of antibiotics other than penicillin and their use by private physicians." Dr. Frances E. Vosburgh of Albany, N. Y., replying to the same question, said, "New developments in therapeutic agents during my thirty years in general practice have made a vast change in the practice of medicine. Thinking of the past five years, we have seen the development of polio vaccine, tranquilizers, and the improvement of the steroids—which, I believe, have been the most important of all."

Women physicians serving in various capacities for the Michigan State Medical Society are: Dr. Alice Palmer, Secretary of Dermatology and Syphilology Section; Dr. Viola G. Brekke, Secretary of Radiology, Pathology, and Anesthesiology Section; and Dr. Goldie B. Corneliuson, Dr. Mary C. Stellhorn, Dr. Kathryn D. Weburg, who are members of the Maternal Health Committee, and Dr. Mary Lou Byrd, who serves as adviser to this Committee.

Dr. Susanne M. Sanderson was honored at a dinner given by Branch Twenty (Blackwell) in Detroit on May 14, 1958. She was presented with a silver pitcher on which was engraved: "To Dr. Susanne M. Sanderson for her many achievements in medicine and for her inspiration to women physicians." Dr. Sanderson is a staff member of Woman's Hospital in Detroit.

Florence B. Seibert, Ph.D., of Henry Phipps Institute, University of Pennsylvania, who holds an honorary degree from Woman's Medical College of Pennsylvania, has received a medical research grant in immunology from the National Tuberculosis Association.

Dr. Mona Spiegel-Adolf presented a paper on "Cerebrospinal Fluid, Serum and Blood Investigation in Amaurotic Family Idiocy" on April 10 at a meeting cosponsored by the Albert Einstein College of Medicine, Yeshiva University, and the National Tay-Sachs Association in New York. She also was a speaker at a meeting of the Federation of American Societies for Experimental Biology, held in Philadelphia on April 17.

Dr. Dorothy Steward presented a paper on "Outlines of Bacteriology and Pathology of Tuberculosis" at the Seventh Annual Symposium for General Practitioners, co-sponsored by the American Trudeau Society, Saranac Lake Medical Society, and the Adirondack Counties Chapter of the N. Y. State Academy of General Practice, on July 7.

ALBUM OF WOMEN IN MEDICINE

EMMA D. KYHOS, M.D.

Dr. Emma D. Kyhos, born in Crawford County, Wisconsin, on Aug. 27, 1892, began her first career, after high school and normal school, as a schoolteacher. Then Emma Dowling married Dr. Roy Brindley, a recent graduate from the Rush Medical School in Chicago. They started medical practice in Hope, Wis., where they had two children, Roy Jr. and Clare, the latter now a physician. After Dr. Brindley's death Mrs. Brindley began another career as laboratory assistant in biochemistry at the Wisconsin General Hospital while she completed work for the bachelor's degree at the University of Wisconsin. This was interrupted by a year in pathology and bacteriology at the Children's Memorial Hospital in Chicago. She received her medical degree from the University of Wisconsin Medical School in 1931, followed by an internship at the Wisconsin General Hospital. During the following nine years she was engaged in general practice. She married again, and had two daughters; one, Mrs. Anne Kyhos Stern, is a graduate in nursing of Bellevue Hospital in New York, and the younger daughter, Elizabeth Kyhos, is entering a teaching career this fall.

In 1941 Dr. Kyhos became a research assistant to Dr. E. L. Severinghaus in human nutrition studies. The patients in Wisconsin General Hospital and volunteer subjects in the Wisconsin State Prison were the human material for four articles of which Dr. Kyhos was joint author. In April, 1945, Dr. Kyhos went as the internist in a team of 14 under the direction of Dr. Severinghaus and Dr. M. B. Visscher of the University of Minnesota, for a year of nutrition study and relief in Naples, Italy. This was a project under the auspices of the U.N.R.R.A. and was sponsored by the service committees of the Unitarian and Congregational churches of America. Dr. Kyhos was the senior author of the only published medical report of this study and mission.

Shortly after returning from Italy, Dr. Kyhos was appointed physician for employees at the Hoffmann-La Roche plant in Nutley, N. J. She became the first full-time physician for this post. The dispensary grew under her leadership to occupy a significant position in the firm. Four nurses, two laboratory technologists, and a part-time physician completed her staff. During her term a co-operative program was built up with the industrial hygiene staff of Hoffmann-La Roche, with resulting decrease in accidents of all types. Periodic physical examinations were added to the pre-employment placement examinations. The dispensary was accredited by the American Academy of Occupational Medicine in 1955.

By maintaining constant contact with the program of clinical research of the firm, Dr. Kyhos was able to anticipate hazards to employees and to develop methods for monitoring employee safety. It is said, however, that her services were most highly appreciated by the employees because of her professional interest as a personal medical adviser. During her dispensary career Dr. Kyhos published a clinical report on "Moniliasis: Side Effect of Antibiotic Therapy."

Dr. Kyhos retired from her position at Hoffmann-La Roche in December, 1957.

Dr. Kyhos has been active in the affairs of AMWA at branch and national levels, serving on committees and participating in panel discussions for programs concerned with industrial medicine. She has also participated in activities of the national Industrial Medical Association. She is a member of the Essex County and New Jersey medical associations and a fellow of the American Academy of Occupational Medicine and of the Industrial Medical Association.

—E. L. Severinghaus, M.D.

Book Notices

Editor's Note: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

TEXTBOOK OF VIROLOGY. Third Edition. By A. J. Rhodes, M.D., F.R.C.P. (Edin.), F.R.S.C., Director, School of Hygiene, University of Toronto; Professor of Microbiology, School of Hygiene, University of Toronto; and Virologist, The Hospital for Sick Children, Toronto; and C. E. van Rooyen, M.D., D.Sc. (Edin.) M.R.C.P. (Lond.), F.R.C.P.(C), Professor of Bacteriology, Dalhousie University, Halifax, Nova Scotia Public Health Laboratory; Consultant Bacteriologist, Camp Hill Hospital, Department of Veterans Affairs; and Honorary Consultant in Virus Diseases, The Royal Canadian Naval Hospital, Halifax. Pp. 642, with 81 illustrations and 22 tables. Price $10.00. The Williams & Wilkins Company, Baltimore, 1958.

This is a welcome third edition of a small but exceedingly useful text, designed to acquaint medical students with the present state of knowledge concerning viruses and rickettsias of medical importance. Since the second edition of the book in 1953, research in this field has added a great deal of new information, and the authors have admirably succeeded in rewriting and reorganizing their book to include the latest and to omit obsolete material. Possibly because they are also the authors of a large reference work ("Virus Diseases of Man"), they do not suffer from the common failing of the textbook writer who feels the compulsion to unburden himself of all his knowledge in the field, no matter how unimportant to the medically oriented reader.

References are used mainly to suggest further reading and not purely to authenticate work quoted in the text. They include some papers published as recently as 1957. The book is 180 pages longer than the second edition (the chapter on poliomyelitis alone has been increased by 15 pages). A new chapter on adenoviruses causing respiratory infections has been added. In the section on diseases caused by *Coxsackie* viruses one chapter has been subdivided into several parts, and brief chapters on virus pneumonia in children, generalized cytomegalic inclusion disease, and acute laryngotracheobronchitis have been added. In other instances existing chapters have been greatly extended, such as the chapter on technical methods, which now includes a brief, up-to-date, and thoroughly adequate presentation of present-day tissue culture techniques.

This is a lucidly written, thorough, and up-to-date text that will serve as a good introduction for the graduate student in virology. It should be read by every medical student and every practitioner who deals with infectious disease.

—Maria Wiener Kirber, Ph.D.

BIOCHEMICAL DISORDERS IN HUMAN DISEASE, Edited by R. H. S. Thompson, M.A., D.M., Professor of Chemical Pathology, University of London (Guy's Hospital Medical School); and E. J. King, Ph.D., D.Sc., F.R.I.C., Professor of Chemical Pathology, University of London (Postgraduate Medical School). Pp. 843, with 121 illustrations. Price $12.60. Academic Press, Inc., New York, 1957.

This is an authoritative and detailed compilation by 31 contributors, each an acknowledged leader in his field. About two thirds of the contributions are from English universities and hospitals, a few are from Scotland and Canada, and the rest are from American universities and university hospitals.

The editors are impressed with the trend in pathology—away from morbid histology and toward morbid biochemistry. They note the rapid strides in biochemical techniques in a wide range of diseases, such as those due to abnormal enzyme action, congenital or acquired, and electrolyte imbalance in cells and in extracellular fluids. Medicine and biochemistry are increasingly interdependent, and relevant discoveries are widely scattered through the medical and scientific literature. This volume seeks to bring such facts together.

The material is dealt with on the basis of the organ system. Since each organ system is written by a different authority, the manner of presentation varies. In some chapters the content goes well beyond a discussion of biochemical disorders and includes a story of the development of our knowledge in the field under discussion. Some chapters include brief descriptions of clinical syndromes, others conclude with statements of present treatment. After each chapter there is a long and up-to-date bibliography. There is a good subject and author index in the back of the volume.

The book is an excellent source for anyone wishing to refer to the newest concepts of physiology and chemical pathology in any organ system and for those who wish to learn of biochemical tools and methods presently used for further research into normal physiology or the chemistry of disease processes. Its organization should make for ease in use.

—Marian Tyndall, M.D.

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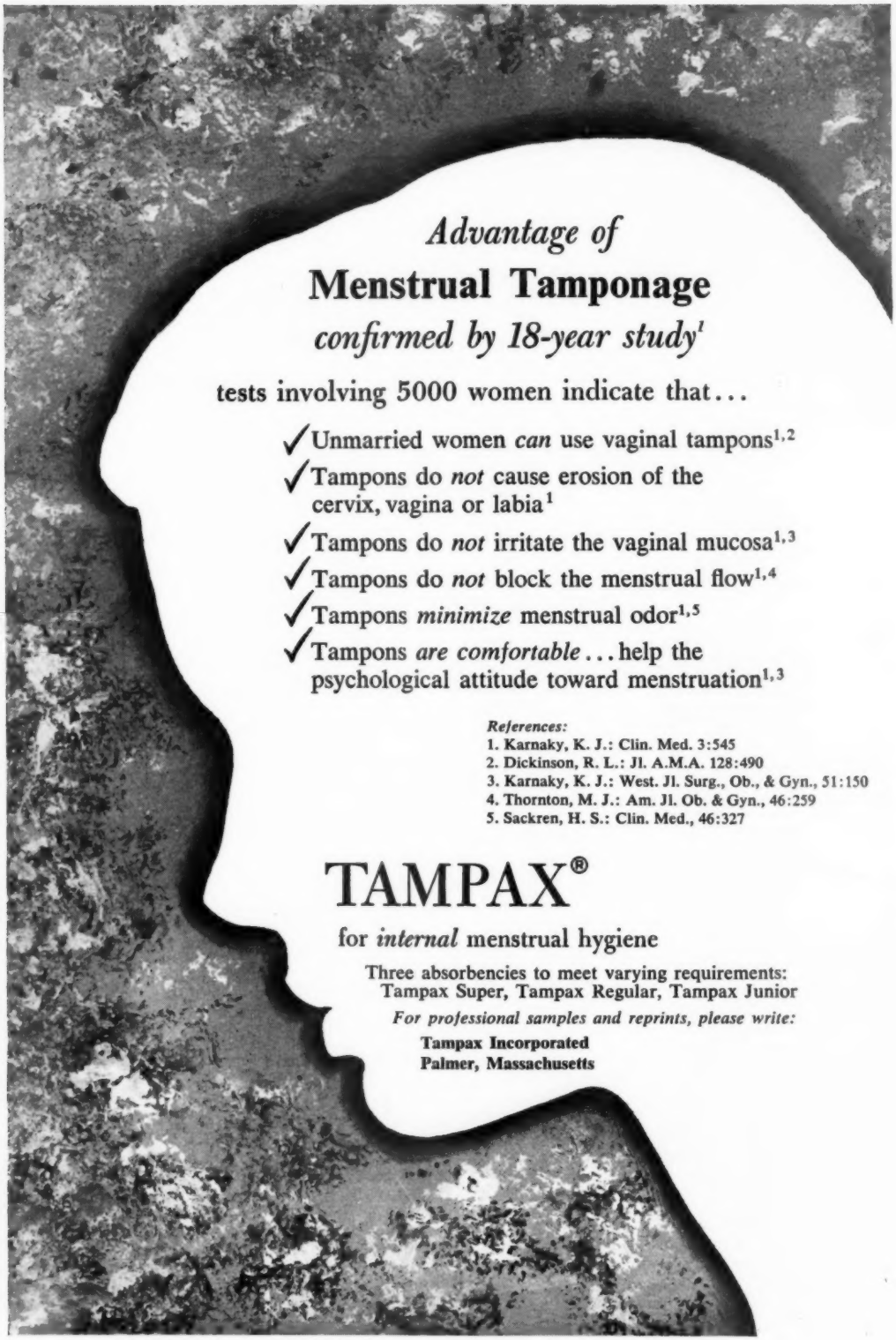

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- ✓Tampons *are comfortable*... help the psychological attitude toward menstruation[1,3]

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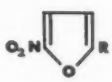

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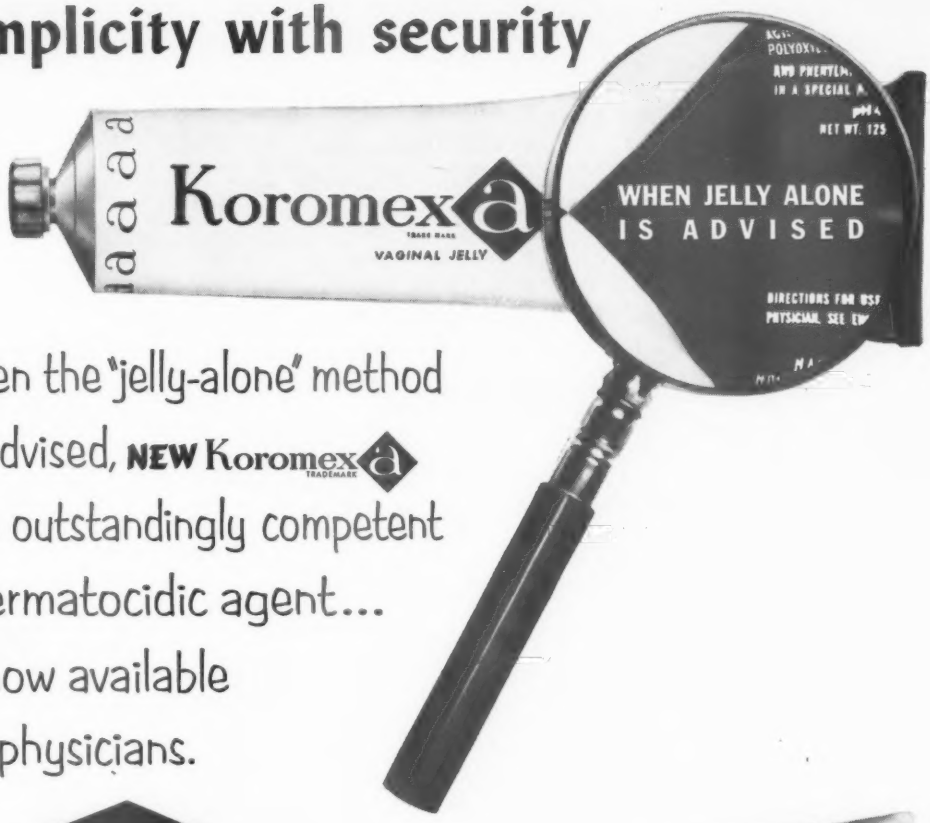

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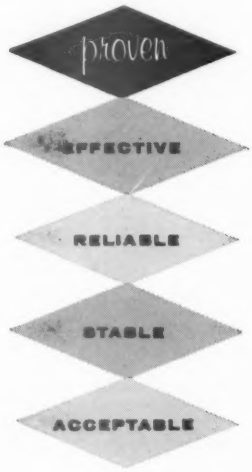

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In Exhaustion and Depression—In a study of over 100 patients suffering from various psychiatric disorders, especially exhaustion and mild depression, the clinical effect of 'Deaner' was to increase energy and to relieve depression in over 70%.

2. Lemere, F., and Lasater, J. H.: Am. J. Psychiat. *114*:655 (Jan.) 1958.

In Learning Problems—Some of the children with reading problems and other learning defects have improved markedly during their treatment with 'Deaner'.

3. Oettinger, L., Jr.: Presented before the American Encephalographic Society Meeting, Atlantic City, June 14, 1958. To be published.

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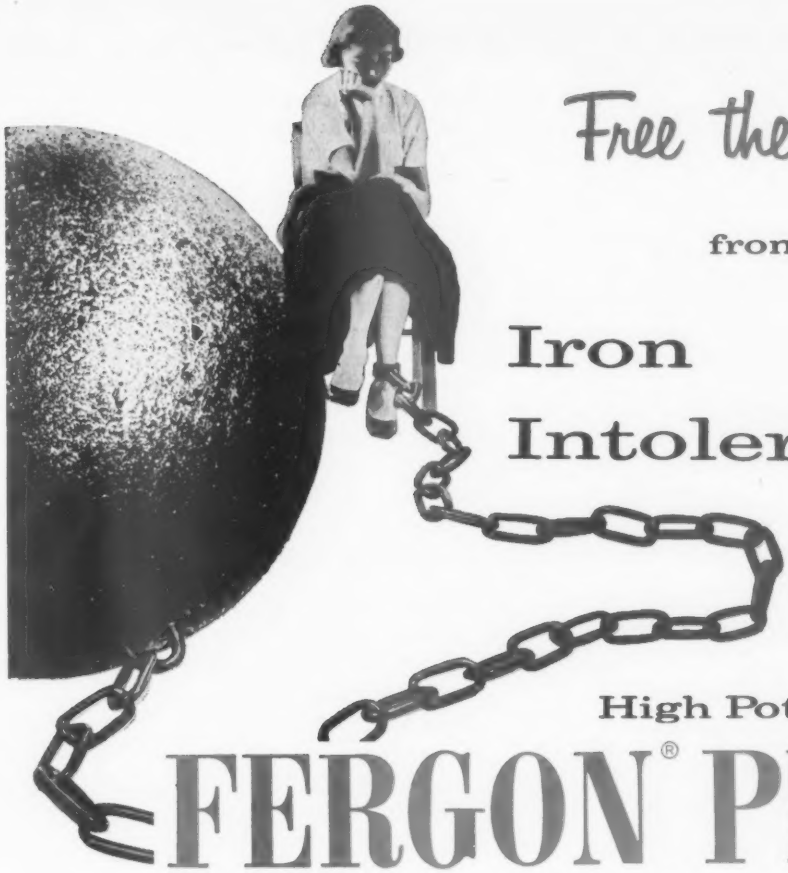

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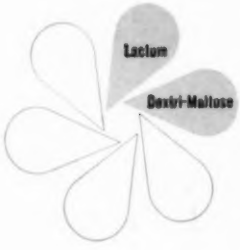

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